DOCUMENT RESUME

ED 315 186 PS 018 582

AUTHOR	Kendrick, Abby Shapiro, Ed.; Messenger, Katherine P., Ed.
TITLE	Health in Day Care: A Guide for Day Care Providers in Massachusetts.
INSTITUTION	Massachusetts State Dept. of Public Health, Boston.
PUB DATE	88
NOTE	568p.; Figure 11 (pages 80-83); figure 23 (pages 139-140); and appendixes 11, 15, and 16 will not reproduce well.
AVAILABLE FROM	State Bookstore, State House, Room 116, Boston, MA 02133 ($11.50, plus $1.75 postage and handling. Make check payable to Commonwealth of Massachusetts.)
PUB TYPE	Guides - Non-Classroom Use (055)
EDRS PRICE	MF02/PC23 Plus Postage.
DESCRIPTORS	Administration; Child Abuse; Child Neglect; Chronic Illness; *Day Care; Disabilities; Early Childhood Education; *Educational Environment; First Aid; Guidelines; *Health; Health Education; Nutrition; *Policy Formation; Prevention; Record Keeping; Resource Materials; *Safety; Sanitation; School Responsibility; *Standards; State Curriculum Guides; Student Transportation
IDENTIFIERS	*Massachusetts; Toilet Training

ABSTRACT

This reference manual and resource guide describes high standards for health policies and day care procedures that reflect current research and recommendations of experts. Chapters 1 and 2, which concern day care's role in health, cover health education in day care and the basics relating to policies, providers, and records. Chapters 3-5 concern the heathful environment. These chapters focus on general environmental concerns, sanitation standards, and toileting. Chapters 6-8 deal with safety at the day care center, transportation safety, emergencies, and first aid. Preventive health services are discussed in Chapters 9-11, which focus on preventive child health care, adult health in day care, and dental health. Chapter 12 concerns nutrition in day care. Special health issues, including services for children with special needs, child abuse and neglect, childhood lead poisoning, and chronic health conditions, are discussed in Chapters 13-16. Chapters 17-19 cover the management of illness, in particular, infectious diseases, care of the mildly ill child, and sick child care models. A final section contains 24 appendices which provide policy outlines, checklists, feeding guides and other practical helps, and references to resources. A total of 60 figures supplement the text. Most chapters provide a list of references. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

PS

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☒ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED315186

HEALTH IN DAY CARE

A Guide for Day Care Providers in Massachusetts

PS 018532

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Abby S. Kendrick
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

A PUBLICATION OF
Preschool Health Program
Division of Family Health Services
Massachusetts Department of Public Health

BEST COPY AVAILABLE

HEALTH IN DAY CARE

A Guide for Day Care Providers in Massachusetts

A PUBLICATION OF
Preschool Health Program
Division of Family Health Services
Massachusetts Department of Public Health

EDITORS
Abby Shapiro Kendrick • Katherine P. Messenger

CONSULTING EDITORS
Francine H. Jacobs • Serena Mailloux, M.D.

DESIGN
Suzi Wojdyslawski

COPYRIGHT 1988, COMMONWEALTH OF MASSACHUSETTS

Any portion of this publication, except those sections previously copyrighted, may be reproduced if credit is given for the source of the material.

Michael S. Dukakis
Governor

Philip W. Johnston
Secretary of Human Services

Deborah Prothrow-Stith, M. D.
Commissioner of Public Health

Massachusetts Department of Public Health
150 Tremont Street
Boston, Massachusetts 02111

Acknowledgments

This Guide could not have been prepared without the expertise, advice, and substantive writing and rewriting contributed by many of our colleagues in the Department of Public Health and elsewhere.

Contributing Authors:

Abby Shapiro Kendrick	All Chapters except the following:
Serena Mailloux, M.D., Lynne Mofenson, M.D., Jo-Ann Harris, M.D, and George Grady, M.D.	Infectious Diseases
Ruth Palombo, Barbara Polhamus, and Beverly Edgehill	Nutrition
Francine Jacobs	Special Needs and Chronic Illnesses
Michelle Miclette, Janice Mirabassi	Safety
Cindy Rodgers	Transportation Safety
Mary Terrell, Howard Wensley	Sanitation Standards
Ellie Goldberg, Paul Hunter, and Mary Jean Brown	Lead Poisoning Prevention
Patricia Wise, Marilyn Hoy-Youngblood, and staff of the Preschool Enrichment Team	Health Screening and Developmental Red Flags
Elba Crespo	Child Sexual Abuse
Massachusetts Department of Social Services	Child Abuse and Neglect

We would also like to thank the following reviewers for their time and assistance:

Susan Aronson
Fran Barrett
Helene Bednarsch
Phil Baimas
Connie Brown
Mary Jean Brown
Linda Burbank
Nancy Carrey-Beaver
Peggy Casey
Lisa Cole
Gregory Connolly
Beverly Larson
Theresa Daniel
Betty Donovan
Joan Doyle
Bess Emanuel
Gail Fenton
Sally Fogerty
Karen Frederick
Beth Fredericks
Donna Haig Friedman
Susan Gallagher
Ellen Goldberg
Mary Greene
Bernard Guyer
Dorothy Hall
Jo-Anne S. Harris
Cathy Hess
Lily Hsu
Karl Kastorf
Roxanne Kaufmann
Nancy Kloczko
Beverly Larson
Mary Leary

Linette Liebling
Anne Long
Phyllis Magrab
Marion Malinowski
Bernadine McQueeney
Janice Mirabassi
Jean Collins Norris
Barbara Polhamus
Elizabeth Pressmen
Virginia Rall
Pamela Romanow
Dennis Rosen
Tanya Ryden
Nancy Schirmer
Ken Schulman
Joyce Sebian
Jack Shonkoff
Benjamin Siegel
Barbara Silverstein
Havi Stander
Linda Truitt
Deborah Klein Walker
Michael Weitzman
Howard Wensley
Jack Wertheimer
Patricia Wise
Linda Yeomans
Marian Zeitlin
David Zuccolo

Editorial Services of New England, in the persons of Patti Hills and Agnes Brite, provided editing and indexing services for the volume.

Finally, we extend our thanks to Mary O'Connor, who, with the assistance of Rea Pfeiffer, Robin Brown, and Guille Loveland, put draft after draft on the word processor with the utmost precision and enthusiasm.

Preface

The Massachusetts Department of Public Health recognizes that you, the day care providers of the Comonwealth, have a very important role in protecting and promoting the health and well-being of young children in your care. Health in Day Care: A Guide for Day Care Providers in Massachusetts has been written to provide you with the health information and guidance you need to do the best job possible.

This document is a *reference manual* and *resource guide* for good health policies and practices. Except for references to regulations which apply to day care, such as portions of the Sanitary Code and Office for Children regulations, you are not required to follow these recommendations at this time. We do hope that as OFC group day care regulations are revised, many of the health recommendations will be included as standards.

The manual reflects the most current research and recommendations from the field of experts in health and day care. We know, however, that in such a new field, there will be changes and new information in the future. We encourage you to add information as you gather it. We expect to provide you with updates on policy and procedures as new advances become known. You may want to start a companion notebook now to keep future updates and memos in one place.

Although many child health topics have been omitted to keep the manual a manageable size, it is still very long and somewhat overwhelming as a whole. In order to use it efficiently, we recommend that you become familiar with the contents of the Guide in general by reading through it quickly at least once.

Afterwards, we recommend that you use it as a reference manual when you have questions or concerns related to a specific topic. Each chapter should become the basis for staff training which you conduct throughout the year. You may use materials from the Guide as handouts, posters, or as you wish. Feel free to copy any of the Guide for staff, parents, your health consultant, or community agencies. We welcome its use by any interested person. We do ask that you acknowledge the source of the material when you reuse it.

We encourage you to use the recommendations of this manual as is, to adapt them to fit your specific needs, or to use them as a basis for designing your own training materials.

Major health gains can be made by some simple steps. For example, washing your hands is the single best thing you can do to prevent the spread of disease. You can accomplish a great deal merely by keeping health in mind as an area of concern. By your careful observations, you may discover an important health problem which may prevent more serious difficulties and treatment in the future. By including toothbrushing as a daily routine, you are teaching children good habits for life. By doing regular safety site checks, you may prevent a tragic injury.

You may find that some recommendations may differ from materials you have received from the Centers for Disease Control (CDC) or from your own health consultant or trainers. Unfortunately, there is not complete agreement within the medical community about specific procedures and treatment. You will make the best decision you can after hearing many points of view. The Massachusetts Department of Public Health is available to assist you when possible. Please use your resource lists to find the help you require.

As with all the other parts of your program, you will have to find a balance between competing interests in establishing comprehensive health policies. At times, you may sacrifice a fun activity, such as the use of a wading pool, in the interest of health. At other times, you may choose to give up the ideal health practice, such as complete separation of diapered from non-diapered children, for the purpose of encouraging better social relationships.

This Guide describes very high standards for health policies and procedures in day care. Some may be impossible to achieve in your setting. However, the Guide has been extensively reviewed by both health *and* child care professionals. No recommendations have been made lightly or without good evidence that the recommended practice is important in protecting children's health. Thus, we would like to see all child care programs fully carrying out these practices. We trust that once you understand the reasoning for these recommendations, you will do the best you can. Don't expect to change everything overnight. Plan carefully and thoroughly before you make any major changes. Set your own pace - but keep trying.

We wish you every success for your program. If you would like additional assistance, please contact the:

Preschool Health Program
Massachusetts Department of Public Health
Division of Family Services
150 Tremont Street
Boston, MA 02111
(617) 727-0944

Table of Contents

PREFACE..v

SECTION I. DAY CARE'S ROLE IN HEALTH

INTRODUCTION...1

CHAPTER 1 THE BASICS: POLICIES, PROVIDERS, AND RECORDS..........3

Introduction...................................3
Health Policies................................3
Staff Responsibilities for Health..............4
Communicating with Health Providers............7
Keeping Health Records........................12
References....................................14

CHAPTER 2 HEALTH EDUCATION IN DAY CARE.........................15

Introduction..................................15
Preschool Health Curriculum...................16
Health Education for Staff and Parents........20
Integrated Health Education...................22
References....................................26

SECTION II. HEALTHFUL ENVIRONMENT

INTRODUCTION..27

CHAPTER 3 GENERAL ENVIRONMENTAL CONCERNS.......................29

Introduction..................................29
Handwashing...................................30
Disposable Gloves.............................33
Space...34
Air Quality...................................34
Food Handling.................................36
Handling Contaminated Items...................36
Groups of Children............................37
A Safe Environment............................38
Risks from Play Materials and Activities......38

Table of Contents (cont.)

CHAPTER 4 SANITATION STANDARDS....................................41

Introduction...41
Housekeeping...42
Handwashing..44
Kitchen Facilities.......................................45
Disposal and Storage of Garbage and Rubbish..............49
Laundry..49
Toilet Facilites...50
Plumbing...51
Ventilation, Light and Heat..............................51
References...52

CHAPTER 5 TOILETING..53

Introduction...53
Diapering..53
Toilet Learning..55
References...60

SECTION III. SAFETY/FIRST AID

INTRODUCTION...61

CHAPTER 6 SAFETY AT THE CENTER...................................63

Introduction...63
Safety Inside the Center.................................65
Safety Outside the Center................................72
Special Safety Tips for Infants and Toddlers.............78
Safety Education...86
References...88

CHAPTER 7 TRANSPORTATION SAFETY..................................89

Introduction...89
Proper Use of Child Car Restraints.......................91
Being Prepared for Emergencies...........................92
Field Trips/Carpools.....................................95
Auto Passenger Safety Education..........................97
References...98

Table of Contents (cont.)

CHAPTER 8 EMERGENCIES/FIRST AID....................99

Introduction....................99
Be Prepared for Emergencies....................99
Emergency Evacuation Plans....................102
First Aid....................105
First Aid Education....................110
References....................117

SECTION IV. PREVENTIVE HEALTH SERVICES

INTRODUCTION....................119

CHAPTER 9 PREVENTIVE CHILD HEALTH CARE....................121

Introduction....................121
Health Histories....................126
Health Observations....................126
Major Health Screenings....................133
Medical Examinations....................138
References....................141

CHAPTER 10 ADULT HEALTH IN DAY CARE....................143

Introduction....................143
Promoting Good Adult Health....................143
Health Examinations....................145
Infectious Diseases in Day Care Employees....................147
When Not to Come to Work....................148
Substitutes and Breaks....................149
References....................150

CHAPTER 11 DENTAL HEALTH....................151
Introduction....................151
Healthy Foods for Teeth....................151
Fluoride....................152
Brushing Teeth at the Center....................153
Dental Health Education....................154
Visits to the Dentist....................155
Special Dental Problems....................157
References....................158

SECTION V. NUTRITION

CHAPTER 12 NUTRITION IN DAY CARE....159

Introduction....159
Feeding Infants....161
Feeding Toddlers....163
Nutritional Principles for All Preschool Children....165
Special Nutritional Problems....173
Feeding Children with Handicapping Conditions....179
Nutrition Education....181
Food Service....186
Community Nutrition Resources....195
References....201

SECTION VI. SPECIAL HEALTH ISSUES

INTRODUCTION....203

CHAPTER 13 SERVICES FOR CHILDREN WITH SPECIAL NEEDS....205

Introduction....205
Resources for Infants and Toddlers....207
Resources for 3-6 Year Olds....207
Resources for All Ages....209

CHAPTER 14 CHILD ABUSE AND NEGLECT....213

Introduction....213
Questions and Answers About the Law....214
Preventing Abuse in Day Care....226

CHAPTER 15 CHILDHOOD LEAD POISONING....229

Introduction....229
Sources of Lead....230
Lead Screening....230
Treatment and Follow-Up....231
Environmental Management....232
Measures to Protect Children....232
References....234

Table of Contents (cont.)

CHAPTER 16 CHRONIC HEALTH CONDITIONS....235

Introduction....235
Allergy....239
Asthma....241
Heart Problems....244
Epilepsy/Seizure Disorder....246
Sickle Cell Anemia....249
Diabetes....250
Review of Emergency Planning Procedures....253
References....254

SECTION VII. MANAGING ILLNESSES

INTRODUCTION....255

CHAPTER 17 INFECTIOUS DISEASES....257

Introduction....257
The Five Commandments of Infectious Disease Control..260
Diseases Spread Through the Intestinal Tract....272
Diseases Spread Through the Respiratory Tract....302
- Common Illnesses....304
- Serious Illnesses....315

Diseases Spread Through Direct Contact....327
- Superficial Infections/Skin Infections....327
- Generalized Infections/Total Body Infections....348

Diseases Spread Through Blood Contact....358
Vaccine-Preventable Diseases....368
Non-Contagious Infectious Diseases....377

CHAPTER 18 CARE OF THE MILDLY ILL CHILD....383

Introduction....383
The Basics....384
Common Minor Illnesses and Symptoms....387
Giving Medication....397
References....400

CHAPTER 19 SICK CHILD CARE MODELS....401

Introduction....401
General Guidelines....401
Sick Care in Day Care Centers....402
Sick Care in Family Day Care Homes....403
Sick Care Services at Home....404
References....404

SECTION VIII. APPENDICES

1. Outline for Writing Health Policies........................405
2. Office for Children Health Care Policy Form.................414
3. Department of Public Health Programs and Services...........417
4. Alternative to a Sink.......................................427
5. Site Safety Checklist.......................................428
6. Playground Safety Checklist.................................435
7. Health Team Members...445
8. Developmental Red Flags for Children Ages Three to Five.....447
9. Selected Early Childhood Developmental Screening Instruments.459
10. Department of Education/Regional Education Centers..........461
11. Growth Charts...462
12. How to Care for Your Back...................................470
13. Fluoridated Communities in Massachusetts....................472
14. Developmental Sequence of Feeding Skills....................473
15. Infant Feeding Guide..476
16. Preschool Feeding Guide.....................................478
17. Sample Weekly Menus...480
18. Facts About the Child Care Food Program.....................482
19. Massachusetts Cooperative Extension Service.................484
Extension Food and Nutrition Education Programs (EFNEP)
20. Department of Social Services Area Offices..................486
21. Office for Children Area Offices............................492
22. Child Care Resource and Referral Programs...................504
23. Resource Guide on Child Sexual Abuse........................506
24. Selected Resources for Health in Day Care...................508

SECTION IX. INDEX...521

List of Figures

1. Sample Curriculum Unit: "A Healthy Heart" 18-19
2. Adult Lesson Plan: Lead Poisoning 23
3. Sample Integrated Health Education Objectives: Dental Health 24
4. Sample Integrated Health Education Objectives: Mental/ Social Health 25
5. How to Wash Your Hands 32
6. Handwashing Procedure 46
7. How to Change a Diaper 56
8. Poisonous Plants 69
9. Unsafe Art Supplies 71
10. PlaySafe Habits 74
11. How to Select Safe Nursery Furniture and Equipment 80-83
12. Safe Fine-Motor Toys for Children Under Three 85
13. Ten Rules for Transportation Safety 90
14. How to Use Car Safety Seats 93
15. Emergency Procedures 112
16. Sample Emergency Transportation Permission Form 113
17. Sample Injury Report Form 114
18. Sample Emergency Phone List 115
19. First Aid Kit List 116
20. Recommended Schedule for Preventive Health Care, Birth - Six Years 123
21. Project Good Health 124
22. Sample Developmental Health History -- Short Form 127-28
23. Sample Child Health Examination Form 139-40
24. Dental Referral Criteria for Three-Year-Old Children 156
25. Ideas for Nutritious Snacks 168-169
26. Dietary Sources of Calcium 174
27. Food and the Child: Ideas for Nutrition Education 184
28. Child Care Program: Meal Pattern Requirement 188
29. Menu Planning Worksheet 189
30. Indicators of Child Neglect 216
31. Physical Indicators of Child Abuse 217
32. Behavioral Indicators of Child Abuse 218
33. Indicators of Sexual Abuse 219
34. Where to Report Abuse or Neglect 222-23
35. Making a Report of Child Abuse or Neglect 224
36. Considerations in Programming for Preschoolers with Health Impairments 236
37. Sample Chronic Illness Health Record 237-38
38. Sample Asthma Record 243

List of Figures (cont.)

39. Immunizations Required for Day Care Children 263
40. Recommended Immunization Schedules:
    A. Childhood Immunization Schedule 264
    B. Children Not Immunized in Early Infancy or Behind Schedule 264
41. Certification of Immunization Form 266
42. Reportable Diseases 267-268
43. Sample Letter on Giardia 281-282
44. Sample Letter on Shigella 285-286
45. Sample Letter on Salmonella 289-290
46. Sample Letter on Campylobacter 293-294
47. Sample Letter on Pinworms 297
48. Sample Letter on Hepatitis A 301
49. Sample Letter on Strep Throat 310-311
50. Sample Letter on Chickenpox 314
51. Sample Letter on Meningococcal Illnesses 318
52. Sample Letter on Hib Disease 322
53. Sample Letter on Impetigo 331
54. Sample Letter on Ringworm 334
55. Sample Letter on Conjunctivitis 337
56. Sample Letter on Scabies 340
57. Sample Letter on Head Lice 345-347
58. Symptoms/Diagnosis/Treatment of Major Sexually Transmitted Diseases 356
59. How To Take a Temperature 389
60. Sample Medication Form/Sample Medication Log 399

Introduction

Day care providers play an important role in protecting and promoting the health of children, families, and yourselves. You can develop a positive approach to health by developing and carrying out policies and educational activities which teach adults and children the principles of health and well-being.

The day care program itself -- including facility, play areas, meals, and housekeeping -- can have a major impact on the health of the children attending. Day care can protect health, help parents identify and seek services for health needs, and play a key role in building healthy behavior into the child's developmental growth. It can also be a very unhealthy environment for a young child. It can ignore health issues and leave a number of problems to be detected only when the child enters public school.

This section of Health in Day Care focuses on several major areas related to the general role of day care in health. The following chapters are included:

- Chapter 1: The Basics: Policies, Providers, and Records
- Chapter 2: Health Education in Day Care

Throughout this section, there are several major concepts to consider:

- The health program at your center must be carefully planned and carried out by developing comprehensive health policies.

- All staff and parents must be aware of and fully understand the health policies of your center.

- The health program at your center should be aimed at children, staff, and parents. It should include and integrate community resources and other health-related providers.

- The experiences of children and families at day care can lay the foundation for future health practices.

- Day care can help promote better child health by monitoring children's use of appropriate health care and offering some preventive health services.

1 The Basics: Policies, Providers, and Records

Introduction

This chapter will discuss the very basic concepts of day care's role in health. These general concepts affect every aspect of a day care program. They provide a foundation from which the day care program can both promote good health and protect children and staff from health risks.

Every day care center must have a written set of health policies. A comprehensive plan must consider all aspects of the program including detailed staff responsibilities for health and health record-keeping. The health program should incorporate specific ways of utilizing and communicating with a health consultant, family health providers, and community health resources. These plans and activities, as well as relationships within the community, become the backbone of the health program at your center.

This chapter will focus on the following topics:

- Health Policies
- Staff Responsibilities for Health
- Communicating with Health Providers
- Keeping Health Records

Health Policies

Health care policies are the "blueprint" for health in your program. They are extremely important because they give you a focus for thinking about health issues and how they relate to other aspects of your program. Health policies should bring together the thoughts of staff, parents and health experts, including your health consultant. Because experiences in your program as well as current medical recommendations change, you should review and revise your policies each year. Your health consultant must approve each change.

TIPS ON WRITING

1. Write policies that are as specific and detailed as possible. Keep in mind the questions WHO (is responsible)? WHAT? WHERE? WHEN? WHY? Be sure that responsibilities are clearly defined.

   For example, policies about the first aid kit might be:

   The director is responsible for purchasing all items for the first aid kit and reviewing its contents every month to be sure all supplies are available. The kit shall at all times contain .... The first aid kit will be stored out of children's reach on the top shelf in the bathroom above the sink. Any teacher who uses first aid must report the incident on the accident report on the day it occurs. The report shall be filed in the child's folder and the center incident log. Parents shall receive a copy as well.

2. Include parents, staff, and your health consultant in a small committee to write or review/revise your policies. After a draft is written, send it to a variety of staff, parents, and medical experts for review. Be sure that the policies are understood and that all groups are willing to carry them out.

3. Organize the policies under topics so that they can be used easily for reference. You may want to have a color code or index for fast use in an emergency. Be sure that all staff, parents, and health consultants have copies for reference when issues arise.

WHAT TO INCLUDE

Appendix 1 presents guidelines for writing new policies or revising your current policies. You should develop policies that work well in your particular setting, in accordance with good health care standards and Office for Children regulations.

The Office for Children requires that their health policy form be posted by every telephone. The outline in Appendix 1 is not meant to replace the OFC-required policy; rather, it provides more detail for developing comprehensive health policies for your program. The OFC form is presented in Appendix 2 for your reference.

Staff Responsibilities for Health

The health policies which you develop for your day care center are an excellent means of protecting and promoting children's health. Through them you create a healthful and safe environment; practice preventive measures such as washing hands and monitoring the safety of the playground; and educate yourselves, parents, and children about health issues.

The staff in a day care program can also play a major role in promoting the health of individual children in the center. While you are not expected to diagnose medical problems, you can add to the information used to make the diagnosis. Daily observation of children over a long period of time plays a critical role in identifying potential health problems.

One of the services caregivers provide is to act as a "switchboard" of health data -- receiver, collector, and distributor of health information. The administrator should obtain a medical record from the physician and a detailed developmental health history from parents. Both the administrator and teaching staff should be familiar with this health information. It is very easy to assume that John, who appears very healthy, has no outstanding health needs; however, if you do not know that he is allergic to bee stings, you could be confronted with a shocking and life-threatening emergency if he is stung. Or, knowing that a child has had an extended early hospitalization may help you to understand her separation difficulties or her reluctance to become attached to staff.

Teachers should be trained in first aid, CPR, and common childhood illnesses. In addition, they must obtain health data on individual children and know how to deal with their specific needs. For instance, asthma is a very common childhood disease. If you have a child with asthma in your center, read his history of treatment and current medications. Read about asthma -- the triggers and signs of distress. Ask the parents how the child responds best during the attack. Use your health consultant or the child's health provider to give you appropriate information. Know what *you* need to do in the event of an attack. With adequate information, you and the child will be able to control the situation with far greater ease and confidence.

The staff also plays the critical role of a health observer. You must be sensitive, conscientious, and systematic in observing a child's health needs on a daily basis. Most teachers greet the child in the morning and take notice of such things as a new haircut or outfit. Look at the child's appearance. Is there any significant change? Through daily observation, you learn a great deal about the child as an individual: typical coloring and appearance, moods and temperament, response to pain and sickness, activity level, and patterns of behavior. Each of these is a vital clue to health.

While you *are* expected to be an observant member of the health team, you are *not* expected to be a health expert. Observe the child, record relevant data, and then report anything unusual to the appropriate person on your staff and to the parents. You cannot and should not offer diagnoses or treatment plans. Health professionals, however, will be able to make better judgments due to the wealth of information you have provided. Health observation is not a screening tool in itself; it is an important first step before screening, diagnosis, or treatment. These topics are discussed in greater detail in Chapter 9.

Each staff person in day care has specific responsibilities in the area of health. The following overview of staff responsibilities is a guide which can be adapted to the needs of your setting.

DIRECTOR OR ADMINISTRATOR

The administrator is responsible for overseeing all health services, policies, and procedures in your program. Specifically, the administrator is responsible for seeing that the following occur:

- developing and carrying out health policies which protect the health of children and staff;
- insuring that staff have the first aid training required by the Office for Children;
- organizing the center, equipment and materials to prevent injuries and the spread of disease;
- exchanging health information with parents during intake;
- collecting and monitoring information for individual health files, including necessary permissions and releases;
- being sure that children receive immunizations and lead screening on schedule;
- taking appropriate action when children are injured or sick, including contacting parents when necessary;
- maintaining a relationship with a health consultant and community health resources;
- supervising caregivers to be sure they follow your health policies;
- assisting families in arranging health care, as requested;

- coordinating health education for children, staff, and parents;
- maintaining a quality food service program, if provided;
- reporting suspected child abuse or neglect to the Department of Social Services.

■ TEACHING STAFF/CHILDCARE WORKERS

The staff who work directly with children are responsible for:

- maintaining a clean, safe, hazard-free, and healthful environment;
- observing children for signs of illness or potential health problems and reporting any concerns to the appropriate person;
- administering medications according to center policy, if designated, in accordance with Office for Children regulations;
- providing health education to children, including daily health routines;
- supervising children to insure safety;
- carrying out any responsibilities delegated or assigned by the center director or administrator.
- reporting suspected child abuse or neglect to the Department of Social Services.

Communicating with Health Providers

■ THE ROLE OF THE HEALTH CARE CONSULTANT

The health care consultant to a day care program should be a physician, nurse or nurse practitioner who has *pediatric* experience and regularly deals with children. It is very important that this individual be familiar with the specific medical and developmental needs of children from birth to five years. Look for a consultant who is aware of early childhood and parenting issues, has knowledge of infectious diseases in group settings, and can promote health among children and adults. Ideally, the consultant should be involved in the local community and familiar with community resources for referral, support, and educational materials. The consultant should be able to develop positive relationships with children, families, staff, other health providers, and the community.

According to OFC Group Day Care Regulations, the consultant "shall approve and aid in developing health care policies for the center, shall approve the plan for first aid training of staff, and shall be available for consultations." [102 CMR 7.07(15)]. In addition, a consultant should:

- provide information about specific medical issues;
- provide advice about group problems such as outbreaks of infectious disease or general health issues;
- explain and advocate for the center's health policies with parents and/or family physician;
- provide staff and parent training, when possible;
- have access to other medical resources to assist in areas beyond his/her expertise.

While it is tempting to seek the consultant's advice about individual situations and cases, it seems best to use his/her services for broad issues and policies which affect the group or program.

ONGOING COMMUNICATIONS

Ideally, your consultant should be in regular contact with your program, not just for emergencies once or twice a year. Invite your consultant to visit the center as often as possible. These visits can help him/her learn more about the center and your children so as to make the most effective suggestions on such topics as safety issues, child interactions, or sanitation procedures.

Ideally, the relationship with your consultant should be flexible so that needs can be addressed as they arise. Remember, no individual can be expected to know everything. As long as your consultant has additional medical backup, your center should be in good hands.

Please share this manual with your health consultant so that s/he is aware of the unique needs of a day care setting.

WHERE TO FIND A CONSULTANT

It is not always an easy task to find a health consultant, especially one who is trained and interested in day care. If you are currently looking for a consultant, this resource list may be a good starting point.

- Neighborhood or community health centers
- Local health clinics or hospital pediatric departments
- Public health nurses
- Visiting nurse associations
- Private health providers (e.g., pediatricians, pediatric nurse practitioners, family doctors, health maintenance organizations)

Remember to be clear from the beginning about your needs, expectations, and ability to pay for services.

THE ROLE OF THE CHILD'S PEDIATRICIAN

According to the American Academy of Pediatrics (AAP), "Current methods of communication between pediatricians and child care providers are often woefully inadequate. Many useful and important data are not shared. Often the child care provider receives only certification of immunization status and documentation of a visit to the pediatrician's office."

In providing continuing health care for the child, the pediatrician has learned a great deal about the child's medical status and personality as well as family strengths. This wealth of information should be shared with day care providers. Likewise, pediatricians could learn more about the child's growth and development from the day care provider's extensive observations. Clearly, good communications are needed in both directions.

There should be a system for exchanging information about the child between the physician and the day care provider.

One example of a system might be to mail your OFC-required six-month progress report, with parental permission, to the physician for his/her record. In this way, the physician is kept up to date on the child's development in all areas from your perspective. You might also suggest that the health form provided by the physician include developmental information from the child's health exams or identify health issues to be followed at day care. (Please see Chapter 9, Preventive Child Health Care, for more information.)

Specifically, the AAP has outlined these common topics for communication between physicians and day-care providers:

- Current state of health and nutrition, including management of colds, diarrhea, bruises, chronic illness, handicapping conditions, and appetite;

- Growth patterns observed over time and their significance for the day-care environment;

- Hearing and vision functioning (e.g. the child with frequent ear infections or the child who needs glasses but doesn't wear them);
- Patterns of development, fine motor skills, communications, self-care, interaction with adults and children, and types of play;
- Family involvement to maintain positive parent-child relationship;
- Child's initial and ongoing adjustment to the program.

All communication with health care providers concerning individual children must be done only with parents' permission.

WHAT IF MEDICAL EXPERTS DISAGREE?

Health issues in day care have begun to be explored only recently. Some information is so new that many health care providers have not yet been trained in current health recommendations. Some research is so new that it remains controversial. A great deal remains to be proven scientifically over a long period of time.

Unfortunately, you may possibly find yourself in the position of getting different opinions from a number of medical experts. In fact, this manual presents some recommendations which differ from those of the Centers for Disease Control (CDC) and may differ from what you have been taught by your health consultant. This may be a confusing and frustrating situation to live through as a "non-health" person. As with all policy decisions, you will have to weigh the facts and make the best decision for your unique setting at that time. If you receive conflicting opinions, we offer this advice:

1. Try to work out your policies with your health consultant *before* difficult situations arise (e.g., how to handle Hib disease or diarrhea at your center before an outbreak occurs). Share these policies with parents.
2. When difficult questions about health or infection arise, ask your health consultant for help.
3. If you still have questions or conflicts, e.g., between your health consultant and a child's pediatrician, contact your local Board of Health.
4. If, after all the above, you are still unclear or unconvinced, and the issue concerns infectious disease, ask your local Board of Health to contact the Massachusetts Department of Public Health, Division of Communicable Disease Control. Or you can call them directly at (617) 727-2686, Ext. 420.

5. If the disagreement concerns some other kind of health issue (e.g., care of a child with a handicap), you should contact your Regional Public Health Office (ask for the Family Health Services Coordinator or the Public Health Nursing Advisor); see Resources in Appendix 3 for locations and phone numbers. Or ☎ call the Preschool Health Program at the Massachusetts Department of Public Health in Boston at (617) 727-0944.

OTHER COMMUNITY RESOURCES

There are a number of health resources either in your local community or nearby. It would be helpful to identify the specific agencies and individuals in your area who can assist the children, staff, and families in your program. You may want to keep a resource file for handy reference when you want additional information, training, and referral services. The following list is provided as a guide for you to begin to explore the resources in your area. See appropriate Appendices for addresses and telephone numbers for some of the most frequently used of these agencies.

✓ Child Care Food Program

Child Guidance or Children's Services Program

Child protective agencies

Colleges and universities

Community health centers

Community mental health centers/ Department of Mental Health

County Extension Service

Department of Public Health/ Regional public health offices

Department of Social Services

Early Intervention Programs

Food Stamp Program

Hospital and health clinics

Local Board of Health or Health Department

Local library

Local medical or dental society

Office for Children

Physicians and other health specialists

Public school system

Voluntary and service organizations

Women, Infants and Children Program (WIC)

Keeping Health Records

There should be a complete, up-to-date health record for each child enrolled in the program. The record should be available to the child's parents in case the child leaves the program or the program closes. There should be clear policies about confidentiality. No information may be released by the program without specific permission from the parent or guardian.

CONTENTS

The health record should contain at least the following information:

- Telephone numbers where parents and at least two emergency contacts can be reached at all times
- The child's regular health care provider, address, and telephone number
- Child's pre-admission medical examination form including immunization status
- Developmental Health History
- Notations about allergies, special diet, chronic illness or other special health concerns
- Emergency Transportation Permission Slip
- All permission slips authorizing non-emergency health care, giving medications, etc.
- Results of all screenings and assessments
- Reports of all injuries or illnesses which occurred at the center
- Medication logs
- Reports of referrals and follow-up action
- Notes about any health communication with parents, health providers, etc.
- All written correspondence about the child's health
- Health observations of staff

The record should be reviewed periodically to be sure that it is up-to-date and that staff are familiar with its contents.

CONFIDENTIALITY

Confidentiality of health records must be maintained to protect the child and family. Use the following guidelines when developing or reviewing your confidentiality policy.

- Health records must be kept away from public access and unauthorized review.
- Information may not be sent to anyone without parental consent.
- Before information can be released, it should be reviewed by parents who must give permission for the release of each type of information collected.
- Phone requests for information on a child enrolled in your program are not acceptable unless the parent has previously instructed you in writing to release information or given witnessed phone consent (by use of an extension line).
- Information originally collected by others and forwarded to you with parental consent becomes part of *your* record, and thus the responsibility of the program.
- All releases of information in a health file should be properly logged.
- Parents have a right to see all information in their child's file.
- Parents must be aware of the nature and type of all information collected and how it will be used.
- Though parents may ask to speak to you in confidence, you must receive this information in a responsible manner. This is particularly true in relationship to child abuse. Your primary responsibility is to protect the child.

References

American Academy of Pediatrics. Committee on Early Childhood, Adoption, and Dependent Care. "The Pediatrician's Role in Promoting the Health of a Patient in Day Care." Pediatrics 74: 157-158 (1984).

American Academy of Pediatrics. Health in Day Care: A Guide for Health Professionals. Evanston, IL: AAP, 1986 (in press).

Aronson, S. S. "Health Policies and Procedures." Child Care Information Exchange, Sept.-Oct. 1983, 14-16.

Massachusetts Office for Children. 102 CMR 7.00: Standards for the Licensure or Approval of Group Day Care Centers, 1978.

Reinisch, E.H. and Minear, R.E., Jr. Health of the Preschool Child. New York: John Wiley & Sons, 1978.

U.S. Office of Human Development Services. Administration for Children, Youth and Families. Head Start Health Services: Health Coordination Manual. DHHS Publication No. (OHDS) 84-31190. Washington, D.C., 1984.

2 Health Education in Day Care

Introduction

During the preschool years, children form habits and attitudes which can last a lifetime. Many adult diseases are linked to poor habits such as smoking, overeating, and lack of exercise. We know that health education can help create good habits and teach children the benefits of eating low sugar snacks, exercising regularly, avoiding poisons, and other healthy behaviors. Through health education people learn enough about themselves to follow good health practices.

Health education works best in the framework of a healthy environment and healthy adult behavior. The center should have healthy routines such as frequent handwashing and toothbrushing. The center should be safe and organized so that children feel secure and cared for. All people, adults and children, must learn respect for other persons and materials. Health education will not make sense otherwise.

In a healthy environment, adults should be models of good behavior. Children learn most from people, not things. If staff talk about the benefits of exercise while they are "low-energy" and slouchy, children will not want to exercise. If adults talk about good foods, but sit in the kitchen smoking, drinking soda, and munching candy, children will not want to eat only healthy food. Adult behavior, attitudes, and appearance all affect children's learning.

The health education process should promote good health by providing information and activities for children, staff, and parents. You can maximize the impact of your health education efforts by addressing the same health topic with all three groups at the same time. While all three groups may be learning about the same topic, the concepts and level of difficulty should be adapted as appropriate. The child health curriculum will be more successful if adults are involved in the process and can reinforce the messages being taught. In addition, adults themselves will also gain valuable health promotion and child development information.

This chapter will discuss both preschool health curriculum and staff and parent health training. Some examples of integrated health education (for children, staff, and parents) will also be provided.

Preschool Health Curriculum

HOW TO INCLUDE HEALTH LEARNING

Health activities should fit into the natural flow of the program. Health awareness should be an ongoing process throughout the year. Routines such as brushing teeth, handwashing, careful food handling, and good nutrition should happen everyday. A health unit or health month is not enough, nor is an occasional puppet show or filmstrip. Health education must be thoughtfully and systematically woven into the year's plans.

When you know what you want to teach, you can capture the "teachable moments" when children are most likely to learn. For example, when a child is sitting in your lap with the sniffles, talk about taking good care of your body when sick (e.g., rest, drink liquids). When a child is going into the hospital for an operation, that is a perfect time to set up a hospital corner and to read hospital books. The spring is a natural time to talk about growing foods and which foods are good to eat -- plant a garden if you can. Talk about sticky and sweet foods while you're brushing teeth.

Learning always has more meaning when:

- It is a concrete experience.
- It is geared toward the skills and interests of the child.
- It fits into the rest of the child's learning and understanding.
- It is taught and reinforced in many different ways - books, discussions, group activities, field trips, films, etc.
- It is tied into all areas of the curriculum - science (growing food), cooking, dramatic play (hospital play), art (drawing your visit to the doctor's office).
- It is reinforced through practice.

WHAT TO INCLUDE

Health education should be interpreted in the broadest sense -- teaching children about well-being. Health education should focus not only on physical health, but also on topics such as emotional health, growing and changing, and the environment. Children should have the opportunity to learn about personal health, the health of those around them, and their world.

Ideally, a health education plan should draw upon the resources of teachers, parents, nutritionists, mental health specialists, special needs staff, and others, including community agencies and resources.

The following list provides some broad topic areas which should be included as part of the preschool health curriculum. Each of these areas has many key concepts which you can develop with input from staff and parents.

- Growth and development
- Similarities and differences
- Families (including cultural heritage and pride)
- Expression of feelings (verbal and physical)
- Nutrition
- Dental health
- Personal hygiene
- Safety (including personal safety)
- Physical health (including care for illness and preparation for hospitalization)
- Awareness of disabilities
- Environmental health

SAMPLE CURRICULUM UNIT: "A HEALTHY HEART"

Figure 1 will give you a better idea of how to take these curricular topics and turn them into an actual preschool curriculum. The example we have chosen is heart health; it is taken from "The Heart Treasure Chest, a Heart Education Program for Young Children," prepared by The American Heart Association. The Heart Treasure Chest includes a curriculum guide, filmstrip, posters, equipment such as a stethoscope, game, recipe cards, and newsletters for parents. The materials suggest how you can plan heart health activities for every interest area of the classroom. Concepts can be reinforced with books, music, fingerplays, art, and games. Individual, small group, and large group activities can all be used. The parent newsletter can support parent involvement and additional learning at home. See Appendix 24 for information on obtaining the complete "The Heart Treasure Chest" for purchase or loan.

Figure 1
Sample Curriculum: "A Healthy Heart"

I. *The Work of the Heart and Ways to Tell If It's Healthy*

A. Key Concepts
- The heart is a muscle in the chest.
- The heart is about the size of my fist.
- Everyone needs a heart to live.
- The heart pumps (works) all the time to pump blood to parts of the body.
- The blood circulates (moves) through the body.
- Doctors can tell if the heart is healthy.

B. Suggested Activities
- Make child-sized heart badges to reinforce the idea that the heart has a different shape than a valentine heart.
- Develop a Science Center that includes a "medical clinic" with a mirror, stethoscope, flashlight (to see blood and blood vessels), cot, doctors' and nurses' coats, tape measures, etc.
- Use a bulb syringe during water play to demonstrate how the heart pumps blood.
- After learning from a chart of the body, ask the children to do body tracing. Allow the children to use red and blue crayons to draw the blood vessels.
- Encourage similar artwork with red and blue paint at the easel.

II. *Physical Activity and Rest*

A. Key Concepts
- Physical activity makes our hearts stronger and healthier.
- We can do many activities to keep our hearts healthy such as running, jumping, walking, and riding tricycles.
- Sometimes we need to allow our hearts to rest. Quiet activities, such as relaxing to music, reading books, doing puzzles, and taking a nap, rest our bodies and our hearts.

Figure 1 (cont.)

B. Suggested Activities

- Set up an obstacle course to include many movements such as walking, climbing, crawling, balancing.
- Play "ball pass" at circle time. Use several balls at once, if you wish.
- Look at pictures to talk about "movement" and "resting" activities. Sort them from most quiet to least quiet. Tell stories about the pictures.

III. *Heart-Healthy Foods*

A. Key Concepts

- Eating a variety of foods keeps us healthy.
- Fruits such as apples, oranges, and bananas are good for us.
- Vegetables such as carrots, squash, broccoli, spinach, sweet potatoes, and greens are good for us.
- Fish and chicken are good for us.
- Cereal without sugar is good for us.
- Lowfat milk, plain yogurt, and cottage cheese are good for us.
- Water is good for us.

B. Suggested Activites

- Plan art activities such as collages of food pictures from magazines. Sort or talk about the foods. Cut sponges into food shapes and use for printing. Make a mural about healthy foods.
- Read the book "Stone Soup." Make stone soup with the children.
- Have a food-tasting party. Use nutritious fruits and vegetables.
- Prepare the same food in different ways such as raw carrot sticks and rounds. Cook and mash carrots; compare the taste and texture.
- Set up a fruit and vegetable market. Collect props such as cans of fruit juice, grocery bags, and signs. Encourage the children to act as clerk, cashier, and customer.
- Set up a smelling activity. Have the children match the smell with a picture of the food.

Health Education for Staff and Parents

■ KNOWLEDGE IS POWER

Having good information is one of the best ways to feel confident and in control. When you know what to do - whether it be taking a temperature, using CPR, or keeping a child relaxed during an asthma attack -- both you and the child are going to benefit from your knowledge. You can provide the necessary care, remain calm, and maintain control. Lack of information often leads to panic in emergencies or improper care, such as spreading disease by not washing hands when necessary.

■ HOW TO GET THE MESSAGE ACROSS

There are some basic ways to teach staff, parents, and volunteers about health, including:

- *Model* good health behaviors -- Practice what you preach!
- Establish good health routines -- e.g., toothbrushing, serving only healthy foods, handwashing.
- Post routines and suggestions throughout your setting -- e.g., emergency plans, handwashing techniques, diapering instructions.
- Teach children good habits -- they will remind you!
- Use a variety of media and training techniques, including:
  - staff meeting discussions
  - workshops/guest speakers
  - newsletters
  - site visits (e.g., hospital emergency room)
  - newspaper clippings
  - posters
  - handouts
  - pamphlets from organizations
  - audio-visual materials

■ TOPICS FOR STAFF/PARENT TRAINING

How do you know what to plan for staff/parent health training? Some topics are required for staff by Office for Children regulations. Training in approved emergency first aid procedures, including mouth to mouth resuscitation, treatment of convulsions and choking *must* be offered to all staff. Beyond that, what is most important for your group this year? Here are some ideas to help you plan:

- The administrator or health consultant should observe the center and consider families' needs, strengths, and weaknesses to suggest topics of immediate and long-term concern.

- Staff and parents should be polled about their needs and interests. It is usually helpful to present a list of suggested topics for reactions. You might ask them to set priorities for their choices.

- Find out the most convenient time to meet with parents. Parents with children in day care have very little time to spare, and staff are busy all day. Is it best at naptime? At the end of the day over a potluck supper? Evenings? Weekends?

- Try to get a sense of the learning style of the parents and staff. Plan "something for everyone" -- speakers, written materials, hands-on experience, films.

- Plan a yearly schedule based on the priority topics from your needs assessment. Revise and update your training plans each year.

Some suggested topics are:

- orientation to the day care setting's health policies
- preventive health practices
- nutritional needs of preschool children
- safety/injury prevention, including transportation safety
- first aid
- management of minor illness
- child growth and development
- child abuse/neglect
- how to be a "health observer"
- cultural views of health
- how to be a good consumer of health services/health advocacy
- health education for young children
- the meaning of health screenings
- chronic illness/special needs
- parenting -- discipline, talking with children

SAMPLE ADULT TRAINING LESSON PLANS

For each topic, you need to:

- List concepts you wish to share.
- Establish objectives.
- Identify resources for speakers and consumer materials such as films, pamphlets, books, posters.
- Determine how and when it should be presented.

A sample lesson plan on the topic of lead poisoning, adapted from Health Power, is shown in Figure 2.

Integrated Health Education

Figures 3 and 4 are examples, adapted from Head Start training material, which show how health education objectives for children, staff, and parents can be incorporated into an integrated curricular model. The advantage of such coordinated health education activities is that parents and staff will be more likely to understand what you are trying to teach and reinforce your efforts. They will become active partners in promoting good health. The examples outline sample integrated educational objectives for the topics of dental health and mental/family health.

Figure 2

Adult Lesson Plan: Lead Poisoning

PURPOSE

Parents and staff will understand the importance of lead screening tests.

CONCEPTS

- Lead poisoning causes mental retardation, anemia, and death.
- Lead in old paint is the primary source of lead poisoning.
- Detection of lead paint is a simple procedure performed on request by local health departments.
- Lead poisoning can be prevented by removing lead from the environment.
- Lead poisoning can be detected by a simple blood test.
- Lead poisoning can be treated.
- The law requires that lead be removed from the interior environment where lead-poisoned children are found.

METHOD: Guest Speaker

Public Health Nurse from the Childhood Lead Poisoning Prevention Program or a comparable local lead poisoning prevention project.

- Have guest speaker show slides on lead poisoning.
- Have guest speaker address the problem of lead poisoning in general.
- Have the speaker discuss the specific measures used to detect and remove the hazards of lead poisoning.
- Pass out forms, letters and educational materials used by the local and state programs.

Figure 3

Sample Integrated Health Education Objectives: Dental Health

CHILDREN

1. Be aware of the importance of teeth to appearance, chewing, and talking.
2. Know proper technique and regularly brush teeth.
3. Know that diet affects teeth.
4. Choose to eat healthful, non-sugary snacks.
5. Accept care from a dental professional.

STAFF

1. Be aware of the importance of teeth to appearance, chewing, and talking.
2. Be aware of the importance of primary teeth.
3. Know how to prevent cavities and gum disease through:
    - plaque removal through proper brushing and flossing.
    - balanced nutrition with a diet low in sugars and empty calorie food.
    - fluoride.
4. Know value of and encourage appropriate preventive dentistry visits annually for children who have reached three years of age.
5. Prevent dental accidents through recognition and removal of potential hazards.
6. Know how to handle a toothache.
7. Know how to handle injuries to teeth.
8. Identify professional resources who encourage parental participation in preventive dentistry.
9. Identify professional resources willing to accept new medicaid dental patients.
10. Know about dental problems such as nursing bottle mouth syndrome and improper bite and how they might be prevented or minimized.
11. Identify sugar as a dental health hazard and encourage and model reduction of sugar consumption through preparation of healthful, non-sugar snacks.
12. Know and practice proper selection and care of toothbrushes.
13. Seek regular dental care themselves.

PARENTS

1. Be aware of the importance of teeth to appearance, chewing, and talking.
2. Be aware of importance of primary teeth.
3. Know how to prevent cavities and gum disease through:
    - plaque removal through proper brushing and flossing.
    - balanced nutrition with a diet low in sugars and empty calorie food.
    - fluoride.
4. Identify sugar as a dental health hazard and prepare healthful, non-sugar snacks.
5. Be aware of the importance of and practice infant mouth cleaning to prevent nursing bottle mouth syndrome.
6. Know and practice proper selection and care of toothbrushes.
7. Prevent dental accidents through recognition and removal of potential hazards.
8. Know how to handle a toothache.
9. Know how to handle injuries to teeth.
10. Recognize importance of reading nutritional and ingredient labels.
11. Seek regular dental care themselves.

Figure 4

Sample Integrated Health Education Objectives: Mental/Social Health

CHILDREN	STAFF	PARENTS
1. Know that it is healthy and normal to express feelings.	1. Provide effective developmental assessment.	1. Develop skills in observing children's feelings and needs.
2. Know that feelings are to be expressed in ways that are not dangerous or traumatic to themselves or others.	2. Recognize and support importance of secure home base.	2. Recognize importance of secure home base.
3. Know that everyone has feelings and everyone needs to have opportunities to express them.	3. Recognize that so-called aberrant behavior is normal reaction to strange situations.	3. Develop ongoing relationships with child care program and community health care providers.
4. Understand "sameness and difference" (both physical and role) and learn to function with all kinds of people.	4. Provide psychologically safe environment for children, staff, and parents.	4. Develop self confidence through participation.
5. Learn they have abilities by experiencing success in daily activities and thereby develop self confidence.	5. Model positivism and acceptance.	
6. Learn that they are part of a family and group.	6. Be aware of own attitudes concerning family, emotional expression, cultural differences, sexual curiosity of children.	
7. Be aware of their bodies and respond appropriately.	7. Develop partnership with parents, using resources of home.	

References

Aronson, S. S. "Health Training." Child Care Information Exchange, Oct. 1984, 25-28.

Miller, J. Web of Life: Health Education Activities for Children, 1975. [Can be ordered from Pennsylvania Department of Education, Bureau of Curriculum and Instruction, 8th Fl., 333 Market Street, P.O. Box 911, Harrisburg, PA 17108.]

Nelson, H. M. and Aronson, S. S. Health Power: A Blueprint for Improving the Health of Children. New York: Westinghouse Health Systems, 1982.

U.S. Office of Human Development Services. Administration for Children, Youth and Families. Head Start Health Services: Health Coordination Manual. DHHS Publication No. (OHDS) 84-31190. Washington, DC, 1984.

Whicker, P. H. Aim for Health. Winston-Salem, NC: Kaplan Press, 1983.

Introduction

The physical environment in your center plays a big role in the health of all children and adults who spend time there. The general environment - the air you breathe, the surfaces you touch, the space around you, the toys you handle, the food you eat - all affect your health and your resistance to illness.

This section will highlight several environmental health issues. It is divided into three major chapters.

- Chapter 3: General Environmental Concerns
- Chapter 4: Sanitation Standards
- Chapter 5: Diapering and Toilet Learning

Each of these topics relate to a number of basic concepts about the environment.

1. Good handwashing and cleaning of the center will help to prevent the spread of disease.

2. Air quality (proper temperature, ventilation, and humidity) and open space help prevent illness and injury.

3. Some play activities and materials carry health risks which must be considered.

4. Food handling requires special sanitation precautions.

5. Diapering and toileting at the center bring particular risks for spreading illness. Specific sanitation procedures are necessary to prevent the spread of disease.

6. The day care center must be properly taken care of and monitored daily to insure adequate environmental control.

3 General Environmental Concerns

Introduction

All of us know that many day care centers cannot totally control their environments. Many spaces are rented and they were not designed to meet children's needs in the first place. Even so, there are many ways that you *can* affect your center's space. While you are working toward ideal conditions, you can develop policies now which will control the spread of infectious diseases and maintain better health. This chapter focuses on several important topics. They include *Handwashing, Space, Air Quality, Food Handling, Handling Contaminated Items, Groups of Children, A Safe Environment,* and *Risks from Play Equipment and Activities.*

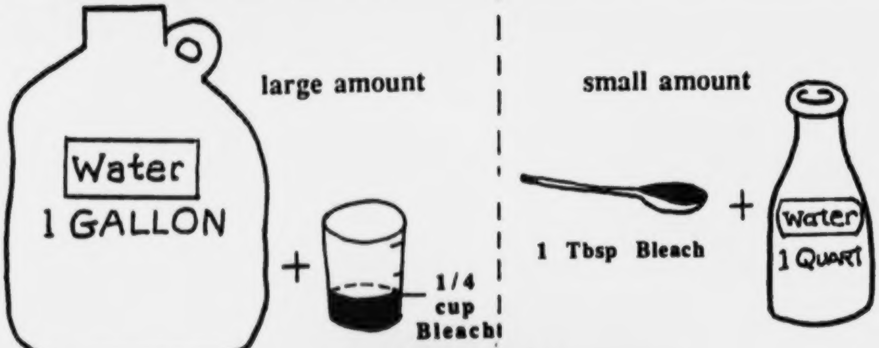
Throughout this chapter and later in this guide, the importance of cleaning surfaces and objects in the day care center with a *recommended bleach solution* will be mentioned. *The standard recommended bleach solution* is *1/4 cup bleach in one gallon water.* This solution should be used for routine, everyday cleaning and disinfecting of items and surfaces (e.g., diaper changing surfaces, table tops, toys, eating utensils).

For certain types of heavily contaminated or very high-risk body secretions, a *strong bleach solution* of *one part bleach in ten parts water* is necessary. This solution, which might gradually corrode some surfaces or cause excessive wear if used routinely, should be used in the following situations:

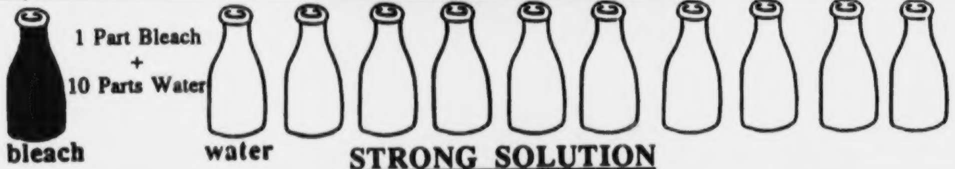
- to clean and disinfect all *blood spills* or blood-contaminated items.
- to clean and disinfect *gross contamination with body fluids*, such as large amounts of vomit or feces. (It is not needed for removing traces of feces or urine from a changing table or small amounts of "spit-up" from a highchair tray.)

- to carry out regular cleaning and disinfecting for a period of time if the center has been experiencing an outbreak of infectious disease.

Throughout the text, we will use the term *recommended bleach solution*. This means *either* the standard or the strong solution, depending upon the nature and extent of the disinfecting job. You must use your judgment to decide which strength is needed. In some cases, when only the standard solution would ever be needed (for example, in regular dishwashing rinse water), or when the strong solution *must* be used (for example, for blood contamination), the specific solution will be referred to in the text.



STANDARD SOLUTION



STRONG SOLUTION

Either of these recommended bleach solutions can be easily made daily at very little cost. There is no need to buy commercially-sold disinfectants. Any bleach solution does need to be made *each day* because bleach loses its strength (and thus its effectiveness) once it is diluted in water.

Handwashing

Handwashing is the first line of defense against infectious disease. Numerous studies have shown that unwashed hands are the primary carriers of infections. When you wash and how often you wash are more important than what you wash with.

Always wash your hands upon arrival at the center, and:

- before eating or handling food
- before feeding a child
- after diapering and toileting
- after handling body secretions (mucus, vomitus, etc.)
- after cleaning
- after giving medication

The five most important concepts to remember about handwashing are:

1. You must use running water which drains out - not a stoppered sink or container. A common container of water spreads germs!

2. You must use soap, preferably liquid.

3. You must use friction (rubbing your hands together). This action removes the germs.

4. You must turn off the faucet with a paper towel. The faucet is considered "dirty" at all times - if you touch it with clean hands, you will be recontaminated. (Ideally, then throw the paper towel into a lined, covered trash container with a foot pedal.)

5. Hand lotion should be available for staff use to prevent dry or cracked skin.

Please refer to Figure 6, page 46, for detailed instructions for handwashing.

POST A HANDWASHING POSTER (FIGURE 5) ABOVE EVERY SINK.

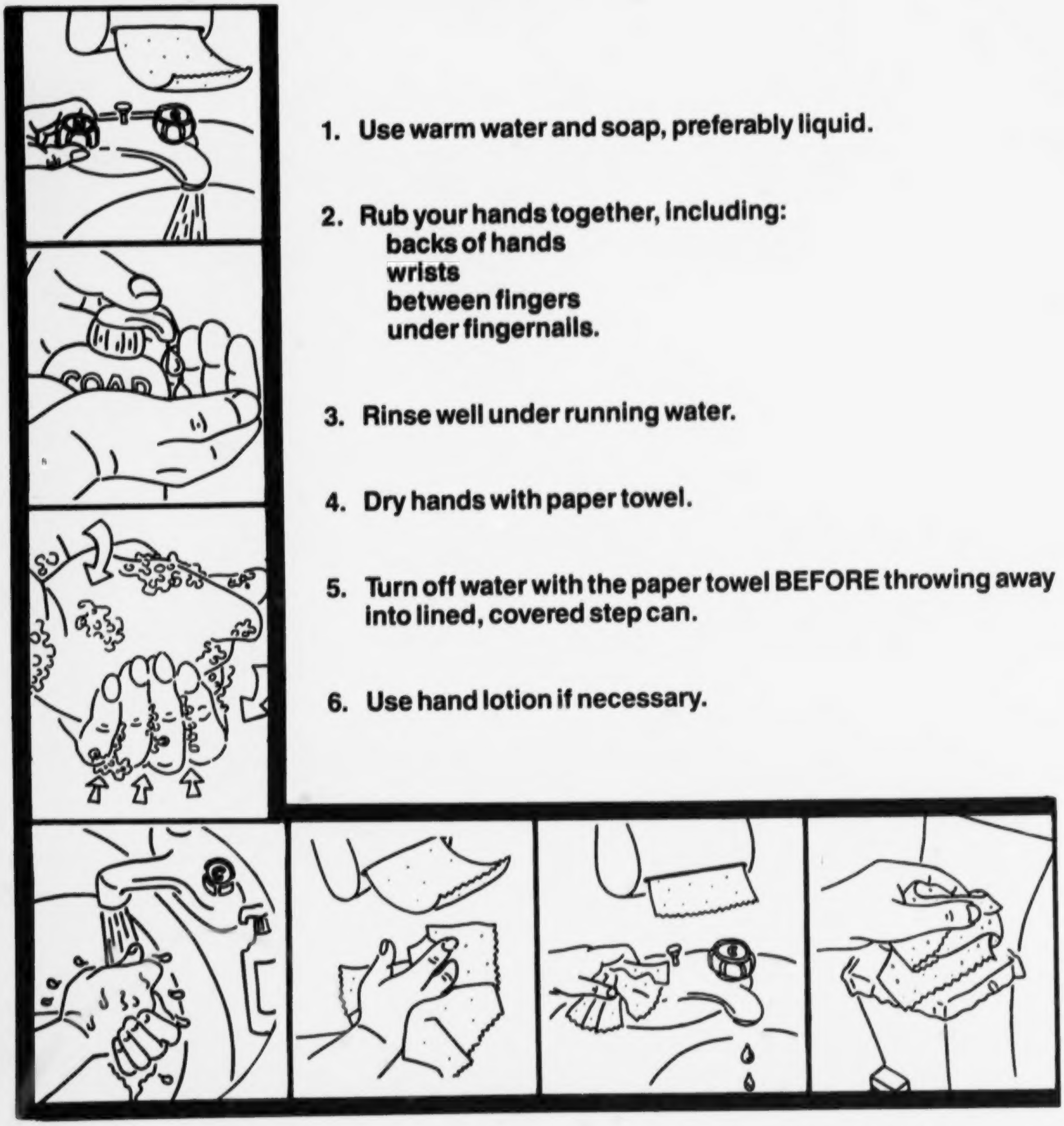
Ideally, sinks should be located near all toileting and food areas. Locate your diapering or changing area next to a sink whenever possible. If you are renovating or building new space, consider installing a sink with a knee or elbow faucet handle to avoid the concerns of recontaminating hands.

Even in centers where new plumbing for sinks is not allowed or is too expensive, you might develop some creative alternatives. One interesting example using a portable water tank "bubbler" is described in Appendix 4.

Portable water alternatives are fine for handwashing as long as:

Figure 5

How To Wash Your Hands



1. Use warm water and soap, preferably liquid.
2. Rub your hands together, including:
   - backs of hands
   - wrists
   - between fingers
   - under fingernails.
3. Rinse well under running water.
4. Dry hands with paper towel.
5. Turn off water with the paper towel BEFORE throwing away into lined, covered step can.
6. Use hand lotion if necessary.

Adapted from: Preschool Enrichment Team, Inc., Holyoke, Massachusetts.
(May be reproduced)

- There is running water - not a common basin.

- The water temperature is not above 110°-115° F.

- A container of contaminated water is out of the children's reach.

- It is safe if children try it (e.g., do *not* use a hot coffee urn for keeping water).

- Soap is available.

There may be times when handwashing is impossible, such as on a field trip. In these cases, disposable wet wipes with an alcohol base are acceptable.

Disposable items such as paper towels, diapering covers, and wet wipes are expensive. Consider buying in large bulk from medical or paper supply companies. Use centralized buying whenever possible; if you are not part of a child care system or large agency, ask other centers near you to join in bulk purchases. It is worth it!

Disposable Gloves

Gloves can be used as a "second line of defense" and can provide a protective barrier against germs that cause infections.

All gloves should be disposable and made of latex. Gloves should be changed after contact with each child. Gloves should *not* be used as a substitute for handwashing. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood and/or body fluids. Hands should be washed *immediately* after gloves are removed.

Disposable latex gloves should be considered in the following situations:

- when changing a diaper of a child with diarrhea or diagnosed gastro-intestinal disease. See chapter 17.

- when contact with blood or blood-containing body fluids from a child is likely, particularly if the caregiver's hands have open cuts or sores, (e.g., when using first aid for a child's cut or changing a diaper with bloody diarrhea).

- when cleaning surfaces that have been contaminated with blood or gross contamination with body fluids such as large amounts of vomitus or feces.

Space

Infections pass more frequently from one child to another when children are confined in small spaces. Children need lots of space to roam, for both developmental and health reasons. Open space and good ventilation decrease the opportunity for germs to pass among children.

The cheapest big space available is the outdoors! Children should play outside *every* day of the year except in cases of *extreme* cold weather or rain. Outdoor play is healthy on many levels - it provides open space to decrease spread of infections, a variety of opportunities for gross motor development, and balance in the child's play and routine. Some children who have particularly high energy levels need lots of outdoor play.

The following are suggestions related to space:

- Do not concentrate toys and equipment in small areas.
- Place cots/cribs at least three feet from each other and alternating foot to head so that air circulates freely and children are not breathing directly on each other.
- Take children outdoors as often as possible, especially during the winter months when the indoors may be overcrowded and overheated.
- Consider a space design which promotes the separation of infants and toddlers from preschoolers to limit the spread of infectious diseases. (Many diseases are spread from children in diapers.)

Air Quality

Attention to the air around you is VERY important. Air quality includes such factors as adequate humidity, temperature control, and ventilation. Dry, hot air in winter takes moisture from skin and mucous membranes. In summer, hot and humid air prevents a child's body from cooling off well; the body tends to overheat. You can do the following:

- Keep air temperature between 65°-72° F if at all possible. (See Chapter 4, page 51, for allowable temperature extremes.)
- Open windows in every room every day to circulate fresh air, even in winter (except in centrally air conditioned or ventilated buildings). Windows must be screened.
- In extremely hot weather, offer more liquids and sponge bathing to prevent overheating and dehydration. You may want to use sprinklers outside for toddlers and preschoolers. Young children, especially infants, become dehydrated more easily than adults.

- In sudden extremes of cold weather, provide extra clothing to maintain body heat. Ask parents to leave extra clothing at the center, if possible, or develop your own supply of extras from unneeded hand-me-downs. (Just remember that shared clothing must be washed between uses by different children if it has been soiled by stool or other body secretions.) Hats should *never* be shared among children.

- Use a humidifier or cool air vaporizer to add moisture to dry air. Do *not* use a steam vaporizer.

- If you use an air conditioner, be sure that it is cleaned and serviced regularly. Air conditioners can build up molds and dust that are harmful allergens for some children and adults.

- Strong odors in the center should be avoided. Some people, including children, have allergic responses to smoke, perfume, room deodorizers, etc.

AND, OF COURSE, NO CIGARETTE SMOKING SHOULD OCCUR WHEN CHILDREN ARE PRESENT. WE RECOMMEND FURTHER THAT SMOKING NOT BE ALLOWED IN ANY CHILD AREA AT ANY TIME. If you feel you must allow smoking inside your center at all, it should be limited to non-child areas such as an office or staff/parent lounge.

■ ASBESTOS

Asbestos is the name given to several naturally occurring minerals which separate into fibers. Asbestos has been used in thousands of products, particularly heat and electrical insulation. If the fibers from these products become airborne and are inhaled, they can cause cancer or lung disease.

Asbestos is a common insulation material on heating pipes, boilers, and furnaces. There are three types of asbestos insulation that are often found on heating pipes. One type is a white or gray asbestos material which is wrapped with cloth or gauze. It looks somewhat like a cast on a broken bone. The second type is corrugated paper which contains asbestos. It is wrapped around the pipe and held in place with tape or with metal clips. Sometimes it also has an outer layer of cloth or gauze. The third type is asbestos paper (not corrugated) which is usually gray or white and looks like cardboard wrapped around pipes and ducts. Other types of pipe insulation such as fiberglass or foam rubber do not contain asbestos.

If asbestos insulation is cracked, torn or crumbling, it can release harmful asbestos fibers. In most cases, the material can be repired to prevent fiber release. However, when the material is beyond repair, it should be removed. Because the repair or removal process can be very dangerous if fibers are released into the air, strict procedures are required by the Massachusetts Department of Public Health. *Repair and/or removal methods must be approved by your local Board of Health.*

If you are concerned that there may be exposed or friable (crumbling) asbestos in your center, contact your local Board of Health or Environmental Health Services, Massachusetts Department of Public Health (617/727-2660).

Food Handling

Improper food handling is a great way to spread infection! Specific guidelines for sanitary food handling appear in Chapters 4 and 12. Please refer to them. Remember:

- Always wash hands before handling food.
- Never allow children to share food from one to the other (e.g., licking the same ice cream, putting used spoons into the same portion of food).
- Always keep food far away from a diapering area.
- If possible, adults who change diapers should not prepare food.
- Keep food and food utensils separate from classroom items.
- If drinking fountains exist, they should be the approved jet angle type with a mouth guard above the rim.

Handling Contaminated Items

Heavily contaminated materials such as tissues, toilet paper, soiled diapers, bandages, soiled clothing, and vomitus are a natural way to spread disease. In general, as few people as possible should handle contaminated items. *BE SURE THAT CLEAN-UP AREAS ARE COMPLETELY SEPARATED FROM FOOD HANDLING AREAS.* Specifically:

- Dispose of soiled items immediately into covered containers. *Use gloves as necessary. See page 33.*
- WASH HANDS IMMEDIATELY!
- Do NOT rinse or wash soiled cloth diapers or clothing. Place in a plastic bag, close it tight, and keep out of the reach of children. Ask the parent to take the items home for laundering. Changes of clothing should be kept at the center.

- All diaper pails should be covered and lined with plastic bags.
- Wash and spray all mouthed toys with recommended bleach solution at least DAILY.
- Wash and disinfect all surfaces in frequent use by children daily with the recommended bleach solution.
- Wash and disinfect changing surface or potty chairs with recommended bleach solution after each use.
- Toothbrushes and personal items should be labeled and used only by their owners.
- Any carpeted areas should be vacuumed daily and shampooed or cleaned as often as necessary.

Groups of Children

A stable group creates a balance which reduces the number of illnesses. Aside from the obvious emotional benefits of low turnover of staff and children, there are health benefits, too. High turnover of children and staff constantly introduces new infections to the center. New children may not be immune to the infections already at the center and may become sick more often. Of course, turnover is a most difficult problem to solve. It is mentioned here so that you will be aware of the health risks involved.

■ SPECIFICALLY:

- Try to keep turnover to a minimum.
- During the outbreak of a serious infectious disease (for example, hepatitis A), new children should not be admitted into the program for some time after the outbreak has ended. Decide the specific time frame with your health consultant, since different diseases need to be treated differently.
- Consider limiting the mixing of children in diapers with older children when possible, although this also may limit developmental learning opportunities. You must decide the balance between these two issues for your center.

Because of the number of comings and goings, large centers (with 50 or more children) open more than ten hours per day appear to be at greater risk for spreading infectious diseases. Such centers should be particularly careful about preventive health routines.

A Safe Environment

Safety is mentioned in this section because it is a key element of every healthful environment. Chapter 6 deals specifically with safety in the day care setting; please refer to it.

Risks from Play Materials and Activities

Some materials and activities at day care carry specific health risks. Our goal is not to create a sterile, hospital-like environment, but rather to help you find a balance between a challenging environment and one that is safe and healthy for staff and children. In order to do this, you should know potential risks and how to handle them.

■ WATER PLAY

A container of water which is shared by many children carries the risks of spreading germs via the water itself and water toys. Germs grow in "warm and wet" environments. If you decide to keep a water table in your setting (and we encourage you to do that), you should:

- Be sure the water table is cleaned and sanitized with the standard bleach solution and filled with fresh water at least daily.

- Have children wash their hands *before* playing at the table.

- Wash and sanitize all toys daily. (Wash with soap and water and spray with bleach solution or put in dishwasher.)

Some experts recommend using individual basins within the water table. The basins can be cleaned and sanitized between children more easily.

■ DRESS-UP CLOTHES

Shared clothing carries the risk of spreading disease, particularly head lice and certain skin infections. Any clothing soiled by stool or other body secretions (mucus, vomitus, etc.) should be removed immediately and not returned until laundered. If there is an outbreak of head lice or scabies you should:

- take away all play clothing until the outbreak has stopped.

- launder and clean all items according to directions listed in Chapter 17 or store in air tight plastic bags for two weeks.

■ INFANT/TODDLER TOYS

All toys used by infants carry the risk of spreading disease, because they are mouthed frequently and passed around. All infant toys should be washable as well as SAFE.

- Hard-surfaced plastic, rubber or other cleanable surfaces should be washed and disinfected with recommended bleach solution at least once daily. Some toys may be dishwasher safe.

- Stuffed toys should be machine-washable and should be washed at least weekly or more often, if soiled.

Toys which cannot be washed according to these guidelines should not be used.

■ POOLS (INCLUDING WADING POOLS)

Pools carry the double risk of spreading disease and possible drowning. Because of these clear health risks, we do not recommend the use of wading pools for young children. We recommend the use of sprinklers instead of pools on hot summer days.

Any container of water (bath tub, wading pool, in-ground or above-ground pool) is considered a possible hazard and must be supervised by an adult at ALL times. The adult should be directly beside the water; for example, supervising a wading pool from a nearby area of the playground is NOT acceptable.

- When a swimming or permanently installed wading pool is provided, it must meet the requirements of and be licensed by the local Board of Health. A permit from the local Board of Health is required.

- A person competent in cardiopulmonary resuscitation (CPR) for young children should be in attendance at all times when the pool is in use. CHILDREN MUST BE SUPERVISED AT ALL TIMES.

- If used, wading pools must be emptied at least daily (or as necessary due to toileting accidents or other contamination).

- Do not use disposable diapers in pools with filters, since they can clog the filters. Use cloth diapers and/or rubber pants.

- Swimming pools must be fenced and locked in accordance with accepted safety practice to prevent accidental or chance access by children or others. Portable wading pools should be drained and upended when not in use.

- Safety rules for the use of pools should be posted in a *conspicuous* location and should be reviewed by the staff.

MOUTH TOYS

Any toys which *must* be used in the mouth should not be allowed or should be considered personal items. These include blowing toys (bubble pipes, horns, tubing for water tables, straws, etc.) and toy thermometers.

SAND

If your sand area is accessible to animals, be sure that it is covered when not in use. Animal feces can spread infectious diseases.

4 Sanitation Standards

Introduction

The purpose of the sanitation standards set forth in this chapter is to help day care centers provide a sanitary, healthful environment for children. Careful sanitary practices can limit the spread of infectious disease. These recommended standards are based on federal and state regulations dealing with sanitation and were adapted for day care centers. The Office for Children licensing regulations are not duplicated in this manual, but in some instances certain areas are expanded upon. Other sources we have used include research articles, recommended standards from the American Academy of Pediatrics, and "Accreditation Criteria and Procedures" of the National Academy of Early Childhood Programs. (See references at the end of the chapter.)

State health regulations which apply to the sanitation practices of day care programs are:

- State Sanitation 105 CMR 410.000 - Minimum Standards for Fitness for Human Habitation (Department of Public Health).
- State Sanitary Code 105 CMR 595.000 - Minimum Sanitation Standards for Food Service Establishments (Department of Public Health).
- State Sanitary Code 105 CMR 435.000 - Minimum Standards for Swimming Pools (Department of Public Health).

☎ If you want to buy a copy, these regulations may be obtained from the State House Bookstore, Room 116, State House, Boston, MA 02133. For further information, call the Citizen Information Service, 800-392-6090.

Electrical and plumbing regulations are available for review at your Town Hall. (They are quite expensive so you probably will not want to buy copies.)

This chapter focuses on standards for the following areas:

- Housekeeping
- Handwashing
- Kitchen facilities
- Disposal of garbage and rubbish
- Laundry
- Toilet facilities
- Plumbing
- Ventilation, light, and heat

Housekeeping

Day care centers should have written policies and procedures for the routine cleaning and maintenance of the facility. Such written policies and procedures should specify the type of disinfectant and cleaning agent used, method for cleaning, schedule for cleaning, and name the person responsible for supervising and monitoring cleaning and other maintenance activities.

■ **STANDARD I.**

THE DAY CARE CENTER IS KEPT NEAT, CLEAN, AND FREE OF RUBBISH.

Guidelines

1. Cleaning should be done in a way that avoids contamination of food and food-contact surfaces.

2. Keep center's soiled linens, aprons, etc., in laundry bags or other suitable containers.

3. Wash all windows inside and outside at least twice a year.

4. Do not use deodorizers to cover up odors caused by unsanitary conditions or poor housekeeping.

5. Keep storage areas, attics, and cellars free from refuse, furniture, old newspapers or other paper goods.

6. Keep flammable cleaning rags or solutions in closed metal containers within locked cabinets.

7. Use the recommended standard disinfectant solution of 1/4 cup bleach to one gallon water. This works well in a spray bottle made up fresh daily. A stronger bleach solution -- one part bleach to ten parts water -- should be used for all blood spills or contamination and for cleaning up gross contamination (e.g., large amounts of vomitus or feces).

8. Wash plastic mats, mouthed toys, commonly used surfaces, etc., at least once a day, spray with recommended bleach solution, and sun or air dry.

STANDARD II.

THE DAY CARE CENTER HAS ADEQUATE HOUSEKEEPING AND MAINTENANCE EQUIPMENT AND CLEANING SUPPLIES. THE EQUIPMENT IS KEPT CLEAN, IN GOOD WORKING CONDITION AND IS STORED SAFELY.

Guidelines

1. Store housekeeping equipment in a separate, locked space such as a closet or cabinet and not in bathrooms, halls, or stairs.

2. Use separate sink with hot and cold running water for cleaning purposes only, when possible.

3. Housekeeping equipment and cleaning supplies should include: wet and dry mops, mop pails, brooms, cleaning cloth, and at least one vacuum cleaner.

4. Launder wet mops, dusting and cleaning cloths and sponges used in non-food areas DAILY, dry mops TWICE A WEEK.

STANDARD III.

THERE IS A PEST CONTROL PROGRAM AT THE DAY CARE CENTER.

Guidelines

1. Exterior windows and doors must have screens.

2. Store insecticides and rodenticides away from child activity areas and in non-food service and storage areas. Storage areas should be kept locked.

3. Instructions on the safe and proper use of these chemicals should be clearly posted.

4. Only a certified pest control operator is allowed to apply pesticides for *crawling insects such as roaches, ants, spiders*. No over-the-counter products should be used for these pests.

5. Over-the-counter products for *flying* insects such as bees, wasps, and hornets are permitted. Read directions carefully, wash your hands after use, and store the product safely out of the reach of children.

6. Bait to catch pests should be out of children's reach and in tamper-proof boxes.

7. No-pest strips are not permitted in food service or sleeping areas. Fly paper is acceptable if changed regularly.

■ **STANDARD IV.**

ANIMALS KEPT AT THE DAY CARE CENTER ARE ADEQUATELY FED, SHELTERED AND ARE KEPT CLEAN.

Guidelines

1. Do not allow birds or animals in areas used for preparing, eating, or storing food.

2. Do not allow turtles or parrots in the center, since they are known to carry disease.

3. Be sure that no child is allergic to the animals at the day care center. Since it may be traumatic to remove an animal after an allergy is discovered, you should think about whether you truly need an animal likely to cause allergy (rabbits, guinea pigs, and other furry animals).

4. Be sure that animals are friendly and have an appropriate temperament to be around children.

5. Clean animal areas frequently. Do not use food service facilities. Wash hands afterwards. Children should *not* assist with pet cleaning and maintenance.

6. Be sure that any animal is checked by a veterinarian before introducing it in the center to assure that it is healthy and appropriately immunized. Be sure it is licensed, if required.

7. Be sure children and staff wash hands after handling animals.

8. Separate animal food and cleaning supplies from food service supplies.

Handwashing

■ **STANDARD V.**

THE DAY CARE CENTER HAS A WRITTEN POLICY THAT SPECIFIES WHEN HANDWASHING IS REQUIRED FOR PERSONNEL AND CHILDREN, DEFINES HANDWASHING PROCEDURE, AND PROVIDES CONTINUING MONITORING TO ASSURE THAT THE HANDWASHING PROCEDURE IS CARRIED OUT ACCORDING TO THE FOLLOWING CRITERIA:

Guidelines (See Figure 6, "Handwashing Procedure.")

1. Wash hands upon arrival at the center.
2. Wash hands BEFORE preparing food, eating, or feeding a child.
3. Wash hands AFTER:
    - Toileting self or a child.
    - Handling body secretions, (e.g., changing diapers, cleaning up a child who has vomited or spit up, wiping a child's nose, handling soiled clothing or other contaminated items).
4. Signs that remind staff and children to wash their hands should be posted in the toilet room, the kitchen, and the area where diapers are changed.
5. Hot water supplied to fixtures accessible to children should be controlled to provide a maximum temperature of 110° to 115° F.

Kitchen Facilities

■ **STANDARD VI**

DAY CARE CENTERS THAT PROVIDE MEALS AND SNACKS TO CHILDREN MAINTAIN A CLEAN KITCHEN WITH ADEQUATE EQUIPMENT AND SPACE FOR FOOD PREPARATION, SERVING, AND STORAGE.

Guidelines

1. Limit direct handling of food by using utensils such as forks, knives, trays, spoons, or scoops.
2. Wash raw fruits and vegetables before use.
3. Cover foods that are stored in the refrigerator and on shelves.
4. Throw away handled leftovers and food left in serving bowls.
5. Pay close attention to "use before" dates, especially on foods that spoil easily (dairy products, mayonnaise, etc.).
6. Do not use the kitchen area as a traffic way or meeting room while food is being prepared.

(Please refer to Chapter 12, Nutrition, for further information about food preparation and service.)

Figure 6
Handwashing Procedure

ADULTS

Turn on water to comfortable temperature. Check that a disposable towel is available.

Moisten hands with water and apply heavy lather of liquid soap.

Wash well under running water for approximately 15 seconds.

Pay particular attention to areas between fingers, around nail beds, under fingernails, and backs of hands.

Rinse well under running water for 30 seconds. Hold hands so that direction of water flow is from wrist to fingertips.

Dry hands with paper towel.

Use paper towel to turn off faucet and discard.

Have hand lotion available.

INFANTS/TODDLERS

Wipe hands with damp towel moistened with a liquid soap solution.

Wipe hands with a towel moistened with clear water.

Dry hands with paper towel.

Turn off faucet with paper towel and discard.

OLDER CHILDREN

Squirt a drop of liquid soap on children's hands.

Wash and rinse their hands in running water directing flow from wrist to fingertips.

Dry hands with paper towel.

Turn off faucet with paper towel and discard.

Teach older children to carry out procedure themselves and supervise.

Hygiene Procedures for Staff Preparing Food

1. Wear clean clothes, maintain a high standard of personal cleanliness, carry out strict hygiene procedures during working hours.
2. Wash hands according to prescribed handwashing technique before preparing and serving food and as necessary to remove soil contamination.
3. Keep hands clean while handling food contact surfaces, dishes, and utensils.
4. Do not prepare and serve food while ill with a communicable disease.
5. If possible, do not diaper children or assist with toileting.
6. Keep hair covered with hairnet or cap while preparing food.

Easy To Clean Equipment and Utensils

1. Use food contact surfaces and utensils that are easy to clean, nontoxic, corrosion-resistant and non-absorbent. (No wood utensils or cutting boards.)
2. Use disposable articles that are made of non-toxic materials. Do not reuse disposable articles.
3. Install appliances so that they and areas around them can be cleaned easily.
4. Be sure food contact surfaces are free of cracks and crevices; pots and pans are free of pits and dents; and plates are free of chips and cracks. Cracks in any surface can harbor germs.

Cleaning Food Contact Surfaces and Utensils

1. Clean all eating and drinking utensils, tableware, kitchenware and food contact surfaces after use.
2. Do not use cloths used for wiping food-contact surfaces for anything else. Cloths and sponges should be kept in bleach solution between use.
3. Wash a spoon or other utensil used to test food before using again.
4. Wash food contact surfaces with recommended bleach solution and sun or air dry.

5. Clean kitchenware and food-contact surfaces that have come in contact with spoiled food.

6. Prescrape and presoak if necessary to remove food particles before washing dishes, pots and pans, and utensils.

7. Wash highchair trays, bottles and nipples in dishwasher if available. If tray does not fit in dishwasher, wash in a detergent, rinse, spray with the recommended bleach solution and air dry.

8. Use the proper concentration of suitable detergent for hand (manual) and machine dishwashing, according to package directions.

9. The recommended procedure for hand (manual) dishwashing:

   - A three-compartment sink or three basins are required for dishwashing, rinsing and sanitizing.

   - Wash dishes in hot soapy water (120° F, 49° C.), then rinse thoroughly.

   - Dip object for one minute in standard bleach solution at a temperature no less that 75° F.

   - Rinse.

   - Sun or air dry. (Do *not* use dish towels.)

10. If dishwasher is used, the recommended temperature of the water is 170° F. Because this temperature is higher than that allowed for hot water heaters, the dishwasher may have to be adjusted to reach this temperature.

11. Clean spoons, knives and forks should be picked up and touched only by handles, not by any part which will be in contact with food.

12. Clean cups, glasses, and bowls should be handled so that fingers and thumbs do not touch the inside or the lip contact surfaces.

Day care centers which do not have adequate facilities for cleaning and sanitizing utensils should use only disposable articles.

Disposal and Storage of Garbage and Rubbish

■ **STANDARD VII.**

THE DAY CARE CENTER IS KEPT FREE OF ACCUMULATED GARBAGE OR RUBBISH.

Guidelines

1. Garbage and rubbish should be stored in containers that are water and rodent proof with tight fitting lids. The containers should be removed from children's areas daily.

2. Garbage and rubbish should be put out for collection no earlier than the day of collection.

3. After the garbage and rubbish are removed, the containers, room or areas should be cleaned.

4. Plastic bags may be used to line covered containers and may be put out for collection, unless prohibited by the local Board of Health. (Store plastic bags out of the children's reach.)

Laundry

■ **STANDARD VIII.**

DAY CARE CENTERS MAKE ARRANGEMENTS TO WASH CRIB SHEETS, COT COVERS, AND OTHER ITEMS BELONGING TO THE CENTER.

Guidelines

1. If there is a laundry room or area, it should have a sink for soaking, an automatic washer and dryer, and locked cabinets for the storage of soaps, bleaches and other laundry supplies. Laundry should be washed with detergent, bleach, and hot water and sun-dried (or in an automatic dryer).

2. If the day care center does not have the facilities for laundering, a written policy and procedure should be available for handling emergency situations and for doing routine washing as needed.

3. Clothing, sheets, etc., that have been soiled with mucus, feces, urine, blood or vomitus should *not* be laundered at the center. They should be placed in a double plastic bag, sealed, and stored away from children. The child's name should be attached to the bag and it should be taken home by the child's parents for laundering.

Toilet Facilities

■ **STANDARD IX**

THE TOILET ROOM IS KEPT CLEAN AND SANITIZED, AND THE FIXTURES ARE IN GOOD WORKING CONDITION.

Guidelines

1. Toilet fixtures and "potty chairs" should be of sanitary design and easily cleaned. After each use of a potty:

   - Empty contents into the toilet.
   - Rinse with water and empty into toilet.
   - Wash with soap and water. Consider using paper towels or disposable "jonny mop." Empty into toilet.
   - Rinse again. Empty into toilet.
   - Spray with recommended bleach solution.
   - Air dry.
   - Wash and disinfect sink.
   - Wash hands.

   Now that you know what is necessary to keep potties clean, you may want to consider if you really want to use them! Suggest that each child have his/her own "potty chair" sent from home if parents wish a child to use a potty rather than the toilet.

2. Toilet paper and holders, towels, and soap dispensers with liquid soap should be available.

3. Toothbrushes should be labeled, and not shared among children.

4. Trash container should be emptied and disinfected regularly. (Use the recommended bleach solution.)

5. Bathroom fixtures should be washed and disinfected with recommended bleach solution at least daily or when contaminated by feces, vomitus, etc.

Plumbing

■ **STANDARD X.**

PLUMBING IS IN COMPLIANCE WITH THE REGULATIONS AND CODES FOR THE COMMONWEALTH OF MASSACHUSETTS AND SHOULD BE MAINTAINED IN GOOD WORKING ORDER.

(See 105 CMR 410.180, 105 CMR 410.300 in State Sanitary Code II - Minimum Standards of Fitness for Human Habitation.)

Ventilation, Light and Heat

■ **STANDARD XI.**

ALL ROOMS ARE WELL-LIGHTED, VENTILATED AND HEATED SUFFICIENTLY.

Guidelines

1. If there is insufficient natural light, properly diffused and distributed artificial light should be provided so there is adequate light in rooms, halls and stairways.

2. Adequate ventilation should be maintained as specified by means of windows that can be opened or by an air conditioning or ventilating system.

3. Room temperature should be maintained as specified by the Office for Children Regulations [102 CMR: 7.11 (4) (a)]: not less than 68° F at 0° F outside; and at not more than the outside temperature when the outside temperature is above 80° F (measured at two feet from outside walls and twenty inches above floor level).

References

Accreditation Criteria and Procedures of the National Academy of Early Childhood Programs. Position Statement of the National Academy. Washington, DC: National Association for the Education of Young Children, 1984.

American Academy of Pediatrics. Committee on Infant and Preschool Child. Recommendations for Day Care Centers for Infants and Children. Evanston, IL: American Academy of Pediatrics, 1973.

Massachusetts Department of Public Health. 105 CMR 435.000 et seq. State Sanitary Code Chapter V: Minimum Standards for Swimming Pools, 1986.

Massachusetts Department of Public Health. 105 CMR 410.00 et seq. State Sanitary Code II: Minimum Standards of Fitness for Human Habitation, 1978.

Massachusetts Department of Public Health. 105 CMR 595.00 et seq. State Sanitary Code Chapter V: Minimum Sanitation Standards for Food Service Establishments, 1978.

Massachusetts Office for Children. 102 CMR 7.00 et seq. Standards for the Licensure or Approval of Group Day Care Centers, 1978.

5 Toileting

Introduction

Toileting and diapering are presented in this chapter because they carry distinct health risks to the day care environment. They should be handled with extreme care from both sanitation and child developmental viewpoints.

Toileting is one of the most basic physical needs of young children. How you handle toileting can have major emotional effects as well. The entire process from diapering infants to teaching toddlers/preschoolers about using the toilet should be a positive one. Diapering time is a chance to have special individual communication with a child. It is a time to show extra caring and support. The all-too-common battle over diapers during the toddler years misses the point. Often the process of toilet learning becomes an unnecessary struggle for control between adults and children.

You can join forces with the part of the child that wants to learn and grow. You help a child gain his/her *own* control with your patience and understanding. This chapter will provide some guidelines for meeting the physical *and* emotional needs of young children.

Diapering

DIAPERING AREA

These are some very important rules about the diapering area:

- The area should be used only for diapering.
- The diapering area should be as far away as possible from any food handling area.

- The diapering area should be close to running water so hands can be washed immediately after changing.

- The diapering surface should be a flat, safe area, preferably three feet above the floor.

- The surface should be clean, waterproof, and free of cracks or crevices. It should be covered with a disposable cover. Paper bags, used computer paper on the wrong side, rolls of paper, etc., are cheap materials to use. Disposable squares may be bought from discount medical supply companies.

- All creams, lotions and cleaning items should be out of the reach of children. Never give a child any of these to play with while being diapered -- a child can be poisoned.

- It is ideal to have a belt or strap to restrain the child. A guard rail or recessed area is a good extra safety measure. If you have no restraint, always keep a hand on the child. *Never leave the child, even for a second.*

■ HOW TO CHANGE A DIAPER

1. Put a disposable cover on the surface. Gather all the supplies that you will need (diaper, disposable wipes, etc.)

2. Hold the child AWAY from your body when you pick him/her up. When you know the child has soiled the diaper, use only your hands to carry him/her. Lay the child on the changing surface. *Never leave the child alone.*

3. Remove diaper. Fold carefully inward and put in covered pail lined with a plastic bag. A foot pedal on the diaper pail is ideal. Be sure that children do not play in the diaper pail after changing.

4. Clean child with disposable wipe. *Use one front to back motion.* Use more wipes if necessary until the child is completely clean. Pay particular attention to skin folds and creases.

5. Pat bottom dry. Use cream or other skin care products only on parent request. *Do not use any kind of powder.* Inhaling the powder can be dangerous.

6. Put on clean diaper. Be sure that clothing is clean and dry. Place any soiled clothing in a labelled plastic bag to be sent home. Children should not handle soiled clothing.

7. Wash child's hands with soap and water (or disposable wipe).

8. Remove disposable surface cover and place in covered diaper pail. Clean diapering surface with soap and water and then spray with recommended bleach solution.

9. Wash your hands according to directions in Figure 6, page 46. *Use disposable latex gloves as necessary. See page 33.*

Remember, diapering time should be a time of friendly and relaxed communication. Once you learn these techniques, they will become second nature and you can focus on the child more.

Figure 7 shows how to change diapers. Please post this poster or a similar one above your diapering area.

■ CLOTH OR PAPER DIAPERS?

In a day care setting, disposable paper diapers are preferred. Paper diapers can be thrown away; therefore, there is less chance of spreading disease. When you use disposable diapers, be sure they are thrown away immediately into a lined, covered pail.

Some children must be in cloth diapers because their skin reacts to disposable ones. If a child cannot wear paper diapers, use extra precautions. Follow the above procedures, but also do the following after #7. The soiled cloth diaper should be emptied into the toilet, put into a plastic bag, which is then tied and closed into a second plastic bag with a name label. (Plastic bags from fruit and vegetables, bread, etc., are a cheap, ready supply.) Put the diaper out of reach for the parent to take home. EVEN IF YOU HAVE A WASHING MACHINE, DO NOT RINSE OR LAUNDER CLOTH DIAPERS AT THE CENTER.

Toilet Learning

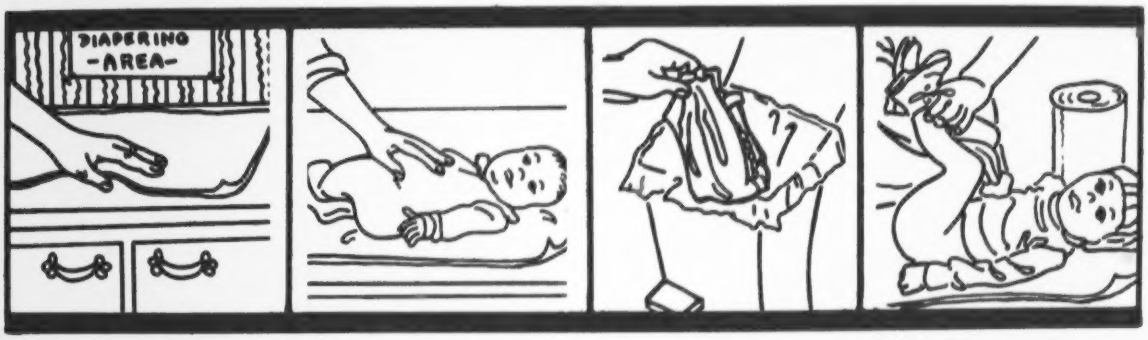
■ WHEN IS A CHILD READY?

In order to assure that the process of toilet learning is a positive one, the child must be ready to participate willingly. Otherwise, toilet "training" can be a battle of the wills and endless "disciplining" and disappointments. The purpose is to help a child get control over his/her body functions. If a child is ready, the process of toilet learning can become a sign of great success and achievement for the child's own sense of "growing up."

There are several landmarks for knowing when a child may be ready.

Figure 7

How To Change A Diaper



1. **CHECK** to be sure supplies you need are ready. **PLACE** paper or other disposable cover on diapering surface.

2. **LAY** the child on the diapering surface. Hold the child only with your hands if the diaper is soiled. Never leave the *child* unattended.

3. **REMOVE** soiled diaper and clothes. **PUT** disposable diapers in a lined, covered step can. **PUT** soiled clothes or cloth diaper in a plastic bag to be taken home. Do *not* put in toilet; bulky stool may be emptied into toilet.

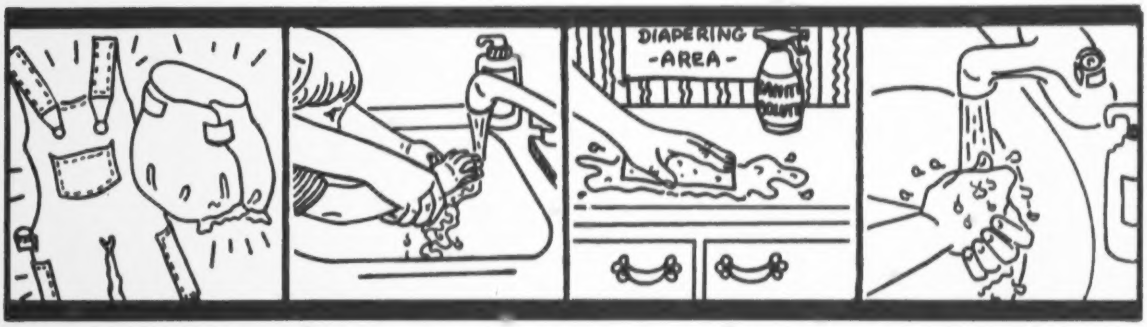
4. **CLEAN** the child's bottom with a moist disposable wipe. Wipe front to back using towelette only once. Repeat with fresh wipes if necessary. Pat dry. **DISPOSE** of the towelette or paper towel in a lined covered step can.

5. Wipe your hands with a moist disposable wipe. **DISPOSE** of it in the lined covered, step can.

6. **DIAPER** or dress the child. Now you can hold him or her close to you.

7. **WASH** the child's hands. Assist the child back to the group.

8. **REMOVE** disposable covering. Wash the diapering area and **DISINFECT** it with bleach solution made fresh daily. Then wash your hands.



Adapted from: Preschool Enrichment Team, Inc., Holyoke, Massachusetts.
(May be reproduced)

Muscle control

The child must be able to work the bottom muscles at will. The child must be able to squeeze the sphincter (bottom) and stomach muscles at the same time. Usually this does not occur until around the second birthday. Some are not ready until age three. If a child cannot do it, probably the muscles (and nerves) are not ready.

Communication

The child should be able to tell with words or consistent gestures that s/he needs the toilet. The child should be able to ask for help undressing or getting to the toilet. Remember to ask parents about the child's "code" words of toileting (i.e., pee, poo, etc.)

Desire

Starting before a child *wants* to learn about the toilet is a waste of time and may set up a lasting power struggle. The child has a natural desire to please those whom s/he loves and trusts. Children also love to imitate! A child will eventually become uncomfortable in diapers and may want to wear underwear instead. *Never force a child to sit on a potty or toilet.* S/he should be able to sit on a toilet or potty without assistance and without fear of falling off.

Parents and day care providers ideally should decide together when the child is ready to begin toilet learning. Different approaches at home and day care will be confusing and may be upsetting. Try to develop a plan together that will be consistent and manageable in both settings. If possible, you should develop similar schedules and use similar equipment.

The process of toilet learning usually is neither fast nor consistent. For some children, the process may take several years to complete. Commonly, children have "accidents" when they are:

- sick (especially with urine infections or diarrhea)
- tired
- excited
- very involved in play
- stressed (e.g., birth of baby, family illness)

Children should not be punished for lapses in using the toilet. If you *expect* some backslide, you will be more apt to accept a child's behavior as normal and all right. Children need your understanding and patience when they are having difficulty in toileting. Your support should actually shorten the time for children to regain their toileting patterns. Punishment will prolong the struggle.

EQUIPMENT NEEDS

Some children will need no special equipment whatsoever except a good supply of extra underpants and clothing. "Training" underpants are extra thick and absorbent and may be helpful, although not necessary, in the beginning.

Some children are insecure or frightened on an adult-sized toilet and may need one or more of the following:

- *Stool* to step up to the toilet - You can use a wooden block or any inexpensive step so that the children can easily reach the toilet. A step also acts as a firm footrest for pushing. This is recommended for all young children who use a toilet.
- *Toilet seat adapter* - A toilet seat adapter fits over the regular seat to make the seat more child-sized and secure. It can be purchased inexpensively at large toy stores. Be sure that it is washable plastic.
- *Potty Chair* - A potty chair is an small toileting chair. Potty chair frames should be made of smooth, non-porous material which is easily cleanable. Wood frames are not recommended. The waste container should be easily removable and fit securely into you must be extra careful when washing them.

HYGIENE WHEN CHILDREN ARE LEARNING TO USE THE TOILET

1. PLACE any soiled clothes in a plastic bag for parents to take home at the end of the day. (Tell parents that washing soiled clothes at the center can spread disease germs.)
2. HELP the child use the toilet.
3. HELP the child wash his or her hands. *Tell him or her that washing his hands will "stop germs that might make him sick."* When children use the toilet, make sure they wash their hands correctly. To do this, you might:
    - Show children how to wash their hands.
    - Watch children wash their hands after they use the toilet, or
    - Ask children if they have washed their hands when they return from the bathroom.

4. If a potty chair is used, empty the contents into the *toilet*. Do not rinse the potty in a sink used for washing hands. *Wash* the potty and spray with recommended bleach solution. (See Sanitation Standard IX, p. 50.)

5. WASH your hands.

HELPFUL HINTS

The best technique of all is to wait until the child is ready and to take the cues directly from the child's own pattern. Beyond that, these suggestions may help:

- Choose clothing that is easy to remove in a hurry. A child must be able to act on an urge to toilet IMMEDIATELY. Avoid tight snaps, lots of buttons, etc. Velcro fasteners are especially easy.

- Use the equipment necessary to make the child feel secure. Always explain the equipment and your expectations for its use. In some cases, it may be best if you flush the toilet or remove the waste after the child leaves the room; the noise or disappearance of the waste may frighten the child. Others may enjoy the sound and action.

- Suggest regularly that the child use the toilet. Common toileting times are after meals, before and after naptime, and before trips. Be sure that you do not expect a child to go only on your schedule. Especially in the beginning, children often need/want to go to the toilet frequently.

- You may decide to ask the child to sit on the toilet for one to five minutes unless the child is upset or uncomfortable. Never insist that the child sit there until "the job is done."

- Always give the child lots of positive feedback and encouragement for success. Do *not* punish the child for failures.

References

Granger, R.H. Your Child From One to Six. DHEW Publication No. (OHDS) 77-30026., U.S. Department of Health, Education and Welfare, Office of Human Development Services. Washington, D.C.: Government Printing Office, 1977.

Provence, S. Guide for the Care of Infants in Groups. New York: Child Welfare League of America, 1967.

Introduction

Safety practices in day care can prevent countless injuries. Surely, prevention is the best method for insuring that people in day care do not get hurt. These same preventive practices will have an effect on family safety as well; teaching good habits -- wearing seat belts, avoiding poisons, checking the environment for hazards -- will have a lasting impact on children and adults.

Unfortunately, despite our best efforts, there are times when emergencies and/or injuries will occur. In those cases, it is crucial that you are well prepared to handle the situation immediately.

This section of Health in Day Care is focused on the preventive health practices for safety at the center and "on the road," as well as basic concepts of emergency/first aid care.

The following chapters are included in this section:

- Chapter 6: Safety at the Center
- Chapter 7: Transportation Safety
- Chapter 8: Emergencies/First Aid

These chapters highlight the following basic concepts related to safety and first aid:

1. Most injuries can be prevented.

2. There should be regular safety checks of the indoor and outdoor environment.

3. Infants and toddlers require special safety precautions.

4. Safety education for staff, children, and parents must be provided.

5. Children and adults must be properly restrained while riding in a vehicle and specific safety rules must be followed.

6. All staff must be trained in first aid and prepared to carry out the center's emergency procedures.

6 Safety at the Center

Introduction

Accidents do not just happen by themselves or by chance -- they are the result of the environment, a child's abilities and personality, and adult supervision and awareness. Sometimes there are hidden dangers that are seen only after a child or staff member is injured. Injuries can often be prevented by:

- Being aware of potential dangers;
- Taking action to eliminate or reduce these dangers;
- Knowing what to do in an emergency.

What is Meant by a Safe Center?

A safe center is arranged so that children can play freely without harming themselves or others. A safe environment allows children to learn by taking risks and challenging themselves and, at the same time, protects them from injury. A sterile, risk-free center and rules that do not let children play and explore are not healthy.

A day care center must follow certain safety standards and practices in order to be licensed by the Office for Children. Local building, sanitary, and fire safety codes must also be observed. These requirements provide some minimal guidelines for the safety of children and staff in your center. This chapter on safety will explain and expand upon those and will offer ideas on how you can make your program safe for both children and staff.

This chapter focuses on the following topics:
- Safety Inside the Center
- Safety Outside the Center
- Special Safety Tips for Infants and Toddlers
- Safety Education

78

The material in this chapter has been developed by the Massachusetts Statewide Comprehensive Injury Prevention Program (SCIPP), which is part of the Massachusetts Department of Public Health. SCIPP has also developed a SAFE DAYCARE module for day care programs. It includes additional ideas on integrating safety practices and education into day-to-day program activities. You can order a copy of SAFE DAYCARE or obtain other safety information from the SCIPP Resource Center, Massachusetts Department of Public Health, 150 Tremont St., Boston, MA 02111; you can also reach the Center at (617) 727-1246.

THE BASICS

- Be alert to actual and potential dangers both inside and outside the center and eliminate or avoid them.

- Look at the world through the eyes of a preschooler - it is colorful, mysterious, and has new places and objects to experiment with and explore. Get down on your hands and knees to see what a preschooler sees. You may be surprised at what you find!

- Conduct regular safety checks. Each room should be checked at least once per month. Sample safety checklists for the center and playground are shown in Appendices 4 and 5.

- Encourage all staff to participate in conducting the checks and planning ways to deal with hazards.

- Know what you're buying or what is being donated to your program. Read labels and instructions carefully.

If you have any questions or complaints about the safety of a product, call the Consumer Product Safety Commission (CPSC) at its toll-free number: ☎ 1-800-638-CPSC

WHEN DO CHILDREN GET HURT?

There are certain situations and times of day when children are more likely to be injured. Some of these are when:

- Another child becomes ill or injured and the routine is disrupted (other children become more at risk)

- Staff are absent or busy

- Children are tired or hungry (for example, immediately before lunch)

- Hazards are too attractive

- Staff are not "up-to-date" with children's abilities

- During field trips, when there are new places to explore and safety rules may be forgotten

Safety Inside the Center

This section offers some specific suggestions for keeping your center safe for children and staff. There are other resources available if you want or need more detailed information. (See Resources section of Appendices.)

■ TRAFFIC AND PLAY AREA

- Make sure there is enough space for all furniture and equipment.

- Bolt top-heavy furniture (e.g., cubbies) to the wall or floor.

- Experiment with different arrangements until you find one which best suits the needs of the children and your program.

- Place chairs and other furniture away from windows, cabinets, and shelves to prevent children from climbing or reaching hazardous items.

- Keep aisles free of toys, furniture, and other tripping hazards such as spilled water. Break up long aisles with barriers to discourage children from running.

- Involve the children in setting rules to limit running, pushing in line, and other such behaviors, and enforce these rules consistently.

■ KITCHEN AND COOKING FACILITIES

- The kitchen should not be accessible to children, unless there is constant adult supervision.

- Other cooking facilities or equipment (e.g, hot plates, toaster ovens) should be out of reach of children.

- Make sure electrical cords and extension cords are not dangling within children's reach.

- Turn handles in toward the back of the stove. Do not carry hot foods or liquids when children are near you.

- To prevent scalds, keep tap water temperature at 110°-115° F.

ELECTRICAL WIRING

- Cover unused outlets with shock stops, and used outlets with outlet covers, especially near sinks. These can be bought in children's or hardware stores.

- Extension cords should run along the wall, behind furniture, to reduce the chance of tripping.

- Store extension cords except when in use.

- When in use, keep extension cords out of the reach of infants and toddlers to prevent mouth burns caused by biting.

- Never run any appliance or extension cord underneath a carpet or rug -- they may become worn or frayed and may cause a fire. Never run them through doorways or walls.

Extension cords may not be nailed to the wall, since they are considered temporary wiring according to the Sanitary Code.

CHOKING HAZARDS

Choking hazards exist for preschoolers during meals and during playtime. Children in this age group frequently use their mouths to explore and experiment with unfamiliar objects.

- Check floors, tables, and all play areas for small objects (under 1 1/2 inches in diameter) that may cause choking, e.g., Lego pieces, beads, coins, small wads of paper.

- Check toys and equipment regularly for small parts that may break off, such as: eyes and noses on stuffed animals, buttons on doll clothes, plastic hats or shoes on miniature people.

- Do not give peanuts to children under four years old.

- Popcorn, hotdogs, and whole grapes should not be given until the child is at least three years old.

- Learn proper techniques for helping a choking infant or child.

- Do not allow balloons in the center. They can be a choking hazard.

- Although you should not allow candy at the center, remind parents that hard candies, gum, and cough drops can be choking hazards.

■ TOYS

Most toys are not dangerous by themselves. The way they are used or misused by a child can cause injury.

- Carefully examine any toys that are given to your center for sharp, splintered or jagged edges and small pieces that can be easily broken off. Tug at different parts to test for strength.

- Cover hinges and joints to prevent small fingers from being pinched or caught.

- Do not purchase projectile toys for your center, e.g., pop-guns, darts. These are not appropriate for children under age eight.

- Bend plastic toys to test for brittleness. Cheap, hard plastic can break easily, leaving sharp edges.

- Test toys for heaviness and for noise level.

- Look for the "non-toxic" label on all painted toys and play equipment.

- Check toys frequently and do minor repairs whenever necessary.

- Keep wooden toys smooth and free from splinters.

- Pull on the heads and limbs of dolls to make sure they won't come off and re-expose sharp wires.

- Look for the "flame retardant" label on cloth toys. Check seams regularly for tearing and weak threads.

- Teach children how to play correctly and safely and to put toys away immediately after playing.

- Reinforce safe play behavior.

■ GROSS MOTOR EQUIPMENT

- Riding toys such as "Big Wheels" and tricycles should be stable and well balanced.

- Matting must be provided under "climbers" inside the center.

- Do not use trampolines. They can cause very serious injuries, and children who are most able to use them are at greatest risk.

- Teach children how to use equipment correctly and safely.

- Reinforce safe play behavior.

POISONS

When you try to identify the poisons in your center, you will probably think first of cleansers and medicines. Chances are your center has many other things that you may not think are poisonous, but which could be harmful if eater or sucked. Poison emergencies are discussed in Chapter 8.

Plants

Plants are a leading cause of poisoning to preschoolers. If eaten, some plants can cause a skin rash or stomach upset -- others can even cause death. *Some common household plants are poisonous.* These include:

- Philodendron (leaves)
- Dumbcane or dieffenbachia (all parts)
- Mistletoe (berry and leaves)

See Figure 8 for a list of deadly household and outdoor plants.

Poisonous plants should be kept out of centers. There are many safe (non-poisonous) plants that can be used for decoration and classroom projects. Some common indoor plants that are safe for growing around young children are listed below.

COMMON NAME (Botanical Name)

African Violet (Saintpaulia ionantha)
Aluminum plant (Pilea cadierei)
Begonia
Boston fern
Coleus (Coleus blumei)
Dracaena
Hen-and-chickens (Sempervivum tectorum)
Jade plant (Crassula argentea)
Peperomia
Prayer plant (Maranta leuconeura)
Rubber plant (Ficus elastica decora)
Sensitive plant (Mimosa pudica)
Snake plant (Sansevieria trifasciata)
Spider plant (Chlorophytum comosum)
Swedish ivy (Plectranthus)
Wandering Jew (Tradescantia)
Wax plant (Hoya carnosa)
Weeping fig (Ficus benjamina)

Figure 8

Poisonous Plants

Children are often attracted to the colorful berries, flowers, fruits, and leaves of plants. But over 700 plants in the U.S. and Canada have been identified as poisonous. These can be found anywhere -- in your neighbor's or your own house, in florist shops and grocery stores, in yards, in the woods, and on playgrounds.

Plants are a common cause of poisoning to preschoolers. Most of these poisonings can be prevented, so it's important for parents, grandparents, babysitters, and day care workers to know if poisonous plants are near children.

If eaten, some plant parts can cause a skin rash or stomach upset; others can even cause death. Here is a partial list of indoor and outdoor plants that are *very dangerous -- CHILDREN HAVE DIED FROM EATING THESE PLANTS.*

Azalea
Baneberry
Belladonna
Black cherry
Black locust
Black snakeroot
Buckeye
Caladium
Caper spurge
Castor bean
Cherry
Chinaberry
Daphne
Delphinium
Dieffenbachia
Duranta
False Hellebore
Foxglove
Golden chain
Jequirity bean
Jimson weed
Lantana
Laurel
Lily-of-the-valley
Lupine
Mistletoe
Monkshood
Moonseed
Mountain Laurel
Mushrooms
Nightshade
Oleander
Poison hemlock
Pokeweed
Rhododendron
Rhubarb leaves
Rosary pea
Rubber vine
Sandbox tree
Tansy
Thorn apple
Tobacco
Tung oil tree
Water hemlock
White snakeroot
Yellow jessamine
Yellow oleander
Yew

There is no rule of thumb to help you tell a poisonous plant from a safe one. You can get help in identifying plants from library books, garden and florist shops, the Cooperative Extension Service, and the Arnold Arboretum in Boston.

If you think your child may have swallowed any part of a poisonous plant, first remove any remaining pieces from the child's mouth. Then bring a piece of the plant to the phone and call the Massachusetts Poison Center, toll-free, 24 hours a day. In greater Boston area: 232-2120. Outside of Boston: 1-800-682-9211.

Most plant poisonings can be prevented with some simple measures:

Learn which plants are poisonous. For help, check library books, garden and florist shops, the Cooperative Extension Service, and the Arnold Arboretum in Boston.

Keep young children away from all plants. Eating too much of even a 'safe' plant can make a child sick.

Remove poisonous plants from the area.

Supervise young children closely around plants.

Teach children not to put plants, fruits, and berries in their mouths.

Please remember that a non-poisonous plant is not necessarily safe to eat.

Arts & Crafts Materials

When buying arts and crafts materials, look for these labels:

- Non-toxic. Item will not cause acute (immediate) poisoning.
- AP: Approved Product. Item contains no materials in sufficent quantities to be toxic or injurious to the body, even if eaten or swallowed.
- CP: Certified Product. Item meets same standards as AP, but also meets specific standards for quality, color, etc.

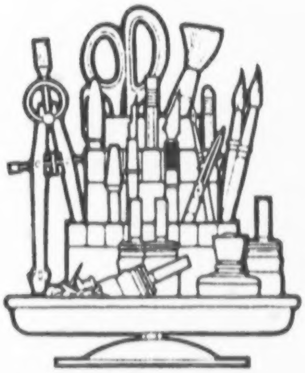
Make sure your current arts and crafts materials have these labels. The safest materials will have the AP or CP labels. If you have any questions, you can call the Arts Hazards Control Institute. (See Figure 9.)

Watch children closely during art projects for mouthing of paint brushes, fingers, crayons, or other objects and materials. Some centers have reported that children are attracted to fruit-scented markers and may try to eat them.

Homemade dough has large amounts of salt and can be dangerous if much is eaten.

Figure 9

Unsafe Art Supplies



AVOID powdered clay. It contains silica which is easily inhaled and harmful to the lungs.

USE wet clay which cannot be inhaled.

AVOID glazes that contain lead.

USE poster paints.

AVOID paints that require solvents such as turpentine to clean brushes.

USE water-based paints.

AVOID cold-water or commercial dyes that contain chemical additives.

USE natural dyes such as vegetables, onion skins, etc.

AVOID permanent markers which may contain toxic solvents.

USE water-based markers.

AVOID instant papier mache which may contain lead or asbestos.

USE black-and-white newspaper and library paste or liquid starch.

AVOID epoxy, instant glues, or other solvent-based glues.

USE water-based white glue or library paste.

AVOID powdered tempera paints.

USE liquid paint or any non-toxic paint.

For more information contact: Arts Hazards Information Center,
5 Beekman Street, New York City, NY 10038

Batteries

Small button batteries found in some toys, cameras, and calculators are a choking hazard and can be extremely poisonous if swallowed. When replacing a button battery, be sure that you discard the old one immediately, away from children's areas.

Cooking and Kitchen Utensils

Activities involving children in cooking and preparing foods are important to the preschool curriculum. In addition to observing safety precautions, make sure that children do not mouth or gnaw on cooking utensils - even the handles. Some utensils have handles painted with lead-based paint which a young child could absorb.

Poisons in Diaper-Changing Area

Staff should be careful about the items given to children to "keep them occupied" during diaper-changing. Sometimes a staff member will grab a bottle of lotion, or a container of talcum powder, for the child to hold. A number of these substances are dangerous if swallowed or inhaled, and a child mouthing a container might eat some of the contents.

Materials used to disinfect a changing surface should be kept well out of reach of the diapering surface.

Safety Outside the Center

■ PLAYGROUNDS

Playgrounds allow children to challenge themselves physically. It is important for children to take risks and experiment, but they can also get hurt. Whether the playground you use is on your property or down the street, you can reduce the chance that a child will be injured by following some basic safety guidelines. These guidelines also apply to home play areas. You may wish to share the following information with parents.

Most injuries are due to misuse of equipment, not to design problems or breakdown.

- Close supervision is needed at all times to prevent misuse of the equipment, such as swinging too high, running close to moving swings, or playing on equipment that is too advanced. If possible, assign extra staff to areas of high risk.

- Check play equipment and its surroundings once a week. The Playground Safety checklist in Appendix 5 is a detailed outline for your use.

- Look for sharp edges, rough surfaces, and loose or broken parts. Cover sharp or protruding parts with masking tape.

- Ground under the equipment should be covered with 8 to 12 inches of a soft, loose fill, resilient material such as pea gravel, wood chips, or soft, frequently raked sand.

- Cement, asphalt, and dirt are dangerous, even with supervision.

- Keep area clean from glass, litter, and large rocks.

- Teach children how to play safely. Involve them in making rules for playground behavior, and enforce these rules consistently. Praise children when they use the playground appropriately. (See Figure 10 on a suggested set of playground safety rules for children, "PLAYSAFE Habits.")

- Remove a misbehaving child from play and explain how his/her actions could hurt somebody.

- Make sure all play areas are protected from streets and traffic to minimize the chance of a child darting into the street.

- Check the outdoor environment for poisonous plants. Remove them, if possible.

- Wood preservatives should be avoided, as they are poisonous. Use pressure-treated wood instead, if possible.

■ TRICYCLES

Have several sizes of tricycles available for the older toddlers and your preschoolers. If a child is too large for the tricycle, it will be unstable. If the child is too small, it may be difficult to control the tricycle properly.

- Low-slung tricycles with seats close to the ground offer more stability.

- For extra stability, look for a wide wheel-base.

- Avoid tricycles with sharp edges, particularly on or along fenders.

- Look for pedals and handgrips with textured or non-skid surfaces to prevent the child's hands and feet from slipping.

Figure 10
Playsafe Habits

For Swings

- Sit in the center of the swing. Never stand or kneel.
- Hold on with *both* hands.
- *Stop* the swing before getting off.
- Stay *far away* from moving swings.
- Only *one* person on a swing at a time.
- Don't swing empty swings or twist swing chains.
- Keep head and feet out of the exercise rings on swing sets.

For Slides

- Be *patient*; wait your turn. Give the person ahead lots of room.
- Hold on with *both hands* climbing up.
- Before sliding down, make sure no one is in front.
- Slide down feet first, sitting up, one at a time.
- After sliding down, *get away from* the front of the slide.

For Climbing Apparatus

Domes or Arches and Jungle Gyms:
  - Only ____ people at a time. (Fill in your limit.)
  - Use *both* hands, and use the "lock grip" (fingers and thumbs).
  - *Watch carefully* for other climbers, and stay away from them.

Horizontal Ladders and Bars:
  - Only ____ people at a time. (Fill in your limit.)
  - Everybody starts at the same end and goes in the same direction.
  - Use the "lock grip" (fingers and thumbs).
  - Keep *a big space* between you and the person in front.
  - Don't use when wet.
  - Drop from bars with knees bent; try to land on both feet.

For Seesaws

- Sit up straight; face each other.
- Hold on tight with *both* hands.
- Keep feet out from underneath the board as it goes down.
- *Tell your partner* when you want to get off. Get off carefully, *and hold your end* so it rises *slowly* until your partner's feet touch the ground.

Adapted from: U.S. Consumer Products Safety Commission, "Play Happy, Play Safe."

- Teach children safe riding habits and check on their habits frequently.

- Do not allow tricycles on sidewalks or near streets, since low tricycles cannot be seen by cars or trucks.

- Do not allow children to ride double. Carrying a passenger on a tricycle makes it unstable.

- Teach children that riding down hills is dangerous. A tricycle can pick up so much speed that it becomes almost impossible to stop without brakes.

- Teach children to avoid sharp turns, to make all turns at low speed, and not to ride down steps or over curbs.

- Advise children to keep hands and feet away from moving spokes.

- Keep the tricycle in good condition. Check regularly for missing or damaged pedals and handgrips, loose handlebars and seats, broken parts, and other defects.

- Cover any sharp edges and protrusions with heavy, waterproof tape.

- Don't leave a tricycle outdoors overnight. Moisture can cause rust and weaken metal parts.

PEDESTRIAN SAFETY

Children learn by imitation and experience. Walks to the nearby playground are "teachable moments" that can be used to introduce and reinforce safe pedestrian behavior.

- Use a travel rope to keep younger children together. Children can hold onto spaced knots in the rope. Make it fun, not confining, by playing "follow the leader" or singing songs.

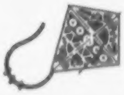
- Staff should explain rules for crossing the streets safely, enforce the rules consistently, and follow these rules themselves.

- Reinforce safety messages. Encourage children to think and talk about the reason behind the actions.

- During walks through the neighborhood, ask children to point out traffic warning signs such as stop lights, signs and crosswalks, and to explain how they help pedestrians (and cars).

- The SCIPP module, SAFE DAYCARE, includes a curriculum unit, SAFEWALKS, which uses five walks to teach these concepts.

FIELD TRIPS

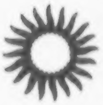


Extra attention to safety is needed during field trips or walks through the neighborhood. Safety rules for indoors may not apply outdoors, and children may be excited about new and unfamiliar surroundings.

- Recruit parents, volunteers from Senior Centers, or students from early childhood courses to help supervise field trips and outings.
- Provide a permission slip for *each* field trip so that you are sure parents approve of the child leaving the center.
- Be a positive role model. Wear safety belts when riding, and cross streets correctly when walking.
- Make sure children understand beforehand the rules for field trips and outings. Involve them in making and enforcing these rules.
- Identify children with a label which states the center's name and telephone number. Do *not* use the child's name.
- Be prepared for an emergency by bringing a "lunch box" first aid kit with you. Include change for a phone and a list of emergency phone numbers, a folder with copies of emergency forms, and the signed permission slips.
- If you are traveling by car, be sure in advance that there are enough vehicles so that each child and adult has a safety belt.

SUMMER SAFETY

Heat and Sun



Warm, sunny weather brings additional areas of concern during outdoor play. Children can be easily burned by the hot sun or by contact with hot surfaces such as asphalt and playground equipment. Dehydration and heatstroke could also occur. Make sure children have access to drinks before and after vigorous play, and at least every two hours during the day.

If there is no natural shade on your playground, you may want to create some by using tents or canopies. (They add lots of new fun and adventure, too!) Limit the amount of time you are in the hottest midday sun (10 a.m. - 2 p.m). Ask parents to authorize sunscreen or to bring protective clothing such as hats or visors.

The skin of young children is more sensitive to the sun than that of adults so it needs more protection from sunburn. At the beginning of the season, gradual exposure is a good practice, starting with five to fifteen minutes the first day and increasing five to ten minutes each day. Although children with darker skin generally can spend more time in the sun than those who have light skin, even children who have dark skin can burn. Please refer to Chapter 18, Sunburn section, for treatment.

Drowning

Drowning is still one of the leading causes of death among young children. There must be constant adult supervision when children are near water (swimming pools, wading pools, ponds, streams, salt marsh, etc.) Children can drown in even a few inches of water. Teach children basic water safety rules right from the start.

1. Swim or play in the water only when you have arranged for an adult to watch you.

2. No running, pushing, or dunking in or around swimming areas.

3. No glass or bottles near swimming or wading areas.

4. No swimming with something in your mouth.

5. Yell for help only when you really need it.

Because drowning is an all too common accident, all adults and older children should learn how to administer mouth-to-mouth resuscitation, the technique to restore breathing.

Insects

Bugs like summer, too. In the later summer insects are busy gathering the sugar from ripe fruits. Stinging insects are often seen swarming around sugary pop containers and trash cans. Although most insects will not sting unless provoked, during late summer and early fall it seems to take less to irritate them. Adults and children should learn to avoid getting excited and moving around rapidly when they see stinging insects. Wild, frightened activity is more likely to result in a sting.

Prevention also includes keeping sticky stuff away from children and adults outside. For this reason, trash cans should be kept outside play areas. Sweet foods like fruits and fruit juices are poor picnic foods unless water is available to rinse off sticky areas after eating. Since perspiration and overheated skin also seem to attract stinging insects, keep children cool and sponged off.

■ WINTER SAFETY

Children should be encouraged to play in and with snow; we New Englanders should take advantage of this wonderful natural resource for daily winter play activities. A number of safety thoughts to remember are:

- *Snowballs can be dangerous,* especially when the snow is packed hard. Also, children sometimes put rocks or other items in the middle of snowballs before they are tossed. Being hit with a snowball, particularly in the face or head, can cause a serious injury.

- Children should not throw snowballs into parking lots, streets, or at moving cars.

- Although eating snow in various forms (snow cones, ice creams from snow, etc.) is fun for the kids, it is *not* good for their health. Particularly in city areas, it can contain dirt or other foreign substances from the atmosphere. *Encourage children to play in the snow and with the snow -- but don't let them eat the snow.*

- Keep a watchful eye on scarves and hoods. They can get caught on playground equipment and have caused strangulation or serious injuries.

Special Safety Tips for Infants and Toddlers

The most important tip when thinking safety with infants and toddlers is: Never assume that a child's motor abilities will remain the same from day to day.

One day a baby could not possibly turn over and fall off a changing table; the very next day the child can give a successful push and end up on the floor! An infant or toddler's natural curiosity can be encouraged in a safe day care environment, if special consideration is given to equipment, and indoor and outdoor play areas.

■ EQUIPMENT AND TOYS

Furniture and equipment for children under three years old must be bought and used with safety in mind. Accidents involving cribs, baby walkers and high chairs are fairly common, and day care centers can reduce the possibility of injury by properly maintaining and supervising equipment.

If you buy or use old infant cribs, be particularly careful about these possible hazards: slats more than 2-3/8 inches apart, ill-fitting mattress, loose or missing hardware, corner posts, decorative cut-outs on headboards, and lead paint.

Figure 11, which is adapted from material prepared by the U.S. Consumer Products Safety Commission, lists the major points to consider when buying or using the following items:

- High chairs
- Baby walkers
- Baby carriers
- Back carriers
- Cribs
- Strollers and carriages
- Playpens

Changing Surfaces

Even though the floor may seem to be the safest place to change diapers, we do not recommend it in a day care center. To prevent the spread of infectious diseases, *the changing surface should be at least three feet off the floor.* Keep diapering and play spaces separate.

Always strap the baby in place if you use a dressing table equipped with straps. Remember, even straps do not always prevent falls; there is no substitute for close supervision.

A table with guard rails offers some additional protection against infant falls, as does a table with a recessed rather than flat top.

Please refer to Chapter 5 for more information.

Toy Chests

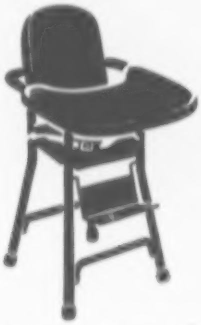
Toy chests are not an appropriate way to display toys in day care. Use low open shelves to increase easy selection and limit clutter and breakage.

If parents wish to buy a toy chest for home use, the Consumer Product Safety Commission advises:

- If chest has a hinged lid, be sure that the lid is lightweight, has a flat inner surface, and a device to hold it open in a raised position so that it will not slam shut of its own weight. Make sure that the device to hold the lid open cannot pinch. They may want to remove the lid to avoid possible danger.

Figure 11

How to Select Safe Infant/Toddler Furniture and Equipment*



High Chairs

HAZARDS

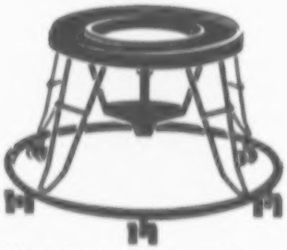
1. Unstable chairs which baby can tip over.
2. Trays which baby can unlatch by pushing against.
3. Seat belts attached to tray instead of chair.
4. Chairs left in path of opening doors, refrigerator doors, range, or other kitchen equipment.
5. Rough or sharp edges on points.
6. Part of a child's body -- usually a finger -- becomes caught or is pinched by high chair part.

SAFETY FEATURES

1. Wide, stable base.
2. No sharp or rough edges or sharp points.
3. Restraining straps sturdy and attached securely to chair itself.
4. Tray which locks securely.
5. If high chair lacks adequate safety straps, purchase a safety harness.

SUPERVISION AND USE

1. Be sure child is strapped in securely whenever in chair; never use tray by itself as restrainer without straps. Even if baby is sitting at the table, the straps should be used.
2. Never allow child to stand up in a high chair.
3. When high chair is not in use, put it in a corner out of the way. If folded up, put it where it can't be knocked over easily.
4. Don't let older children hang onto high chair while a baby is in it.
5. Make sure child's hands are up and out of the way when attaching or detaching the tray.



Baby Walkers

HAZARDS

1. Tipping over when the baby is maneuvering over thresholds or throw rugs or when leaning, running, or reaching in the walker.
2. Finger entrapment in the older x-frame walkers when the walker partially collapses.
3. Falling down stairs when baby is unsupervised and stairs are unguarded.

SAFETY FEATURES

1. Stability -- wheel base should be wider and longer than frame of walker.
2. Sturdy materials; unbreakable plastic or tough fabric seats with heavy-duty stitching or large rugged snaps.
3. Protective covers over coil springs and hinges, no sharp points, exposed screws.

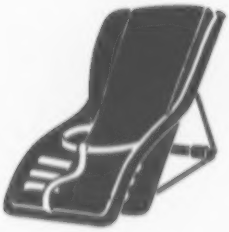
SUPERVISION AND USE

1. Remain with baby while he/she is using the walker.
2. Prevent the child from running or leaning too far.
3. Make sure throw rugs are removed and stairs blocked. Help the baby maneuver over thresholds.
4. Place guards at top of all stairways or keep stairway doors closed to prevent falls.

---

*Adapted from U.S. Consumer Product Safety Commission, "Nursery Furniture and Equipment Can Be Dangerous," 1977.

Figure 11 (cont.)



Baby Carriers

HAZARDS

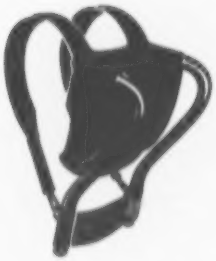
1. Narrow base, slippery bottom surface.
2. Placing carrier on slippery or high surface.
3. Supporting devices on back which may collapse.
4. No safety straps.

SAFETY FEATURES

1. Sturdy materials and wide, stable base.
2. Safety strap.
3. Nonskid bottom surface.
4. Supporting device which locks firmly in place.

SUPERVISION AND USE

1. Always stay with baby.
2. Always use safety straps.
3. If bottom is slippery, attach rough surfaced adhesive strips.
4. When using carrier on high surfaces, make sure the child is within arm's reach and out of reach of dangerous objects.
5. Use the carrier only as intended -- it is not a car seat.
6. Check supporting device to make sure it is firmly in place.



Back Carriers

HAZARDS

1. Using frame back carriers too soon -- baby should be 4-5 months old and able to hold head up.
2. Unpadded frames near baby's face and head.
3. Jolts to baby's neck.
4. Baby slipping out of carrier.
5. Joints that accidentally close and pinch.

SAFETY FEATURES

1. Padded covering over frame near baby's face.
2. Leg openings small enough to prevent baby from slipping out.
3. Leg openings big enough to avoid chafing baby's legs.
4. Strong stitching or large, heavy-duty snaps to prevent accidental release.
5. Seat belts.

SUPERVISION AND USE

1. Buy carrier to match baby's size and weight.
2. Always use restraining straps.
3. Be sure leg openings do not chafe baby's legs.
4. When leaning or stooping, bend from knees to minimize chance of baby falling out.
5. Avoid sharp points, edges, and rough surfaces.
6. Avoid joints that can accidentally close and pinch or cut the baby.

Figure 11 (cont.)

Cribs

HAZARDS

1. Plastic wrapping on mattresses.
2. Mattresses too small for crib; baby can get stuck between mattress and sides and suffocate.
3. Crib slats too far apart; baby could wriggle through, get head stuck, and strangle.
4. Crib so small baby can climb out.
5. Large toys, objects or bumper pads baby can climb on and fall out.
6. Dangling strings in which child may get caught and strangle.
7. Finials (decorative devices on cornerposts) and cutouts where child's head may become caught.

SAFETY FEATURES

1. No more than 2-3/8 inches between slats (about 3 adult fingers width).
2. Snug-fitting mattress. If you can fit 2 adult fingers between mattress and sides, then mattress is too small.
3. Crib sides which lock at maximum height.
4. No rough edges or exposed bolts.
5. Safe materials, e.g., nonlead paint (particularly important with older or used equipment).
6. Latching device which cannot be released easily.
7. No filials, cutouts, or decorative knobs.

SUPERVISION AND USE

1. Check latches to make sure they are secure.
2. Check slats on side rail for closeness and install bumper pads if too far apart.
3. Until you can replace a mattress that does not fit snugly, roll large towels and place them between mattress and crib sides.
4. Check baby's standing height on mattress against side rail; if height of rail is less than 3/4 child's height when the mattress is in the lowest position, obtain a larger crib, or graduate the baby to a regular bed.
5. Remove large toys or any objects the baby may stack or use for climbing.
6. Never hang any stringed object (including toys) on bedpost -- a child could become caught in it. Never put a loop of ribbon or cord around child's neck.
7. Remove and destroy all plastic wrapping materials on crib mattress. Never use plastic cleaning or trash bags as mattress covers.

Strollers & Carriages

HAZARDS

1. Inadequate or faulty brakes.
2. Latches which don't hold securely.
3. Sharp edges or exposed hardware; dangerous scissor-like mechanism. Especially, exposed hinges where children's fingers may be pinched or severed.
4. Canopy which doesn't lock firmly in place.

SAFETY FEATURES

1. Stroller should not tip over with child as far back as possible in it; test reclining back.
2. Firm, vertical, or nearly vertical back rest; child's head should be supported.
3. Firmly attached safety belt, waist strap or harness.
4. Tightly locking brakes; a two-wheel brake provides extra security.
5. Wide base and wheels with large diameters.
6. Canopy which locks in forward horizontal position and rotates to downward position in rear.
7. Shopping basket should be mounted in front of -- or centered over -- rear axle for stability.
8. Plastic coverings over exposed hinges.

SUPERVISION AND USE

1. Check brakes before taking baby for a ride; *use* them when stroller is not in motion.
2. Make sure baby is safely strapped in.
3. Watch baby at all times; don't leave infant unattended.
4. If stroller or carriage is collapsible, check latch devices for security.
5. Don't allow other children to pull or stand in (or on) the shopping basket.

Figure 11 (cont.)

Playpens

HAZARDS

1. Too small a playpen for a growing child; baby shouldn't be able to crawl over the side or cause pen to tip over by leaning his or her weight against it.
2. Mesh playpens with large open weave which child can use as toehold for climbing.
3. Netting with weave large enough for buttons on baby's clothing to get caught.
4. Protruding bolts, rough edges.
5. Hinges which don't lock tightly.
6. Large toys which can be used for climbing left in playpen.
7. Slats which are loose or more than 2-3/8" apart.
8. Weak floors; no padding on floor.
9. When one side of playpen is left down, child may roll into space between mattress and loose mesh side and suffocate.

SAFETY FEATURES

1. Mesh netting with a very small weave, smaller than tiny baby buttons.
2. Slats no more than 2-3/8" apart.
3. Firm floors with a foam pad.
4. Hinges that lock tightly; no sharp edges.
5. Vinyl covering of railings and padding thick enough to resist being chewed and bitten off by teething children.

SUPERVISION AND USE

1. Bring playpen indoors after use outdoors. Rain water and sun can damage it.
2. If slats are placed too far apart, interweave sheeting among them and fasten securely.
3. Remove large toys, bumper pads, boxes, or any objects which could be stacked and used for climbing.
4. Never hang any stringed object (including toys) on cornerpost; a child could become caught in it. Never put a loop of ribbon or cord around child's neck.
5. Keep an eye on baby; be aware of what baby is doing.
6. Never leave infant in playpen with one side of playpen down.

- Check for rough or sharp edges on all metal components and for splinters and other rough areas on wooden boxes.

- Rounded and padded edges and corners may prevent some injuries and reduce the severity of others.

- The toy box or chest should be well ventilated. This means ventilation holes in the lid and at least one side, near the top; ventilation holes near the top at two opposite sides; or a product with a lid that cannot close completely.

- It should not be possible to lock the lid of the toy box or chest.

Toys

General information about toy safety was presented earlier on page 67. Any toys that babies can grab or find should be checked and rechecked regularly to make sure they are safe. For instance:

- There should be no small objects that can be swallowed. Toys should be at least 1-1/2 inches in diameter.

- Toys which can be separated into smaller parts (e.g., Lego cars) should also be avoided or used only with constant adult supervision.

- Large or heavy stuffed animals should not be placed in cribs during nap time. There is a risk of suffocation.

Some examples of *fine motor* safe toys for children under three years are shown in Figure 12. There are many other, larger safe toys also.

Toy and Rattle Test. The CPSC has a special device for testing the size of rattles, but you can do the same thing:

1. Draw an oval 1-3/8 inches by 2 inches (35mm x 50mm) on a piece of cardboard.

2. Cut out the oval hole.

3. If the rattle or any part of it can pass through this hole to a depth of 1-3/16 inches (30mm), it could choke a child.

Remember, a child's mouth is very pliable and stretchable.

Figure 12

Safe Fine-Motor Toys for Children Under Three

UNDER ONE YEAR OLD

Sturdy rattles
Shatterproof mirror
Brightly colored objects hanging in view (mobiles, etc.)
Washable dolls and stuffed animals (with riveted eyes)
Brightly colored cloth or rubber balls
Soft stacking blocks
Squeaky toys (with unremovable squeakers)
Pull toys (with strings no longer than 12 inches)

ONE TO TWO YEARS OLD (In addition to above)

Nesting toys
Ring stack sets
Large, lightweight spinning top
Books with cloth pages
Plastic blocks
Wooden threading beads (large size)
Pop-it beads (large size)
Banging musical instruments (e.g., xylophone)
Toy telephones
Large-sized crayons (non-toxic)
Plastic kitchenware (lightweight, without sharp edges)

TWO TO THREE YEARS OLD (In addition to above)

Simple jigsaw puzzles with large pieces
Wooden blocks (lightweight)
Size-shape matching toys (for example, hollow plastic
  sphere with holes of varying shapes for shaped blocks
  to be pushed through)
Color, content matching games (for example, Lotto,
  crayons, and magic markers)
Large-size magnets

■ INDOOR PLAY AREAS

Centers with infants and toddlers should make sure that enough floor space is available for crawling and toddling children. *These floors should be clean, free of splinters and cracks, and not highly polished.*

Toddler and infant play areas should be separate from the general play area for older children. This will encourage the younger children to explore without the danger of the older children knocking them over. A carpeted area should be maintained for quiet activities and beginning large motor movement by infants. Check that older children have not left toys in the infant area that may be dangerous to them. Top-heavy furniture such as shelving or cubbies must be bolted down to avoid toppling.

Toddlers must be well supervised in classrooms near water-tables and in bathrooms near toilets and deep-basin sinks. All these are naturally of great interest to young children, and with the unsteady gait of toddlers, present a potential drowning hazard.

■ SLEEPING ARRANGEMENTS

Placement of cots and cribs is an important safety issue. Try to remember:

- Leave a cleared walkway (aisle) between cribs. In an emergency, staff must have quick access to each child.

- Do not place cribs near window blinds or shade cords. Long cords are dangerous because they can be wrapped around a child's neck.

■ OUTDOOR PLAY AREAS

Since infants and toddlers spend much more time on the ground than the older preschoolers, check the playground *daily* for items which can be hazardous.

It is also very important that close adult supervision occur if toddlers and preschoolers are outdoors together. The older children can be taught to "watch out" for the younger children and to serve as their mini-protectors in the outdoors play areas.

Safety Education

Providing children with the skills to prevent accidents and care for themselves and others in case of emergency is important. Your own attitudes and behaviors toward safety are as important as the physical set-up of your center. There are different ways to give safety messages to children and staff.

- Be a positive role model.

- Give clear statements when explaining the correct, safe way to do something.

- Reinforce safe behavior by rewarding children for doing things safely.

- Involve the children in making and enforcing rules. This will increase their safety awareness and help them feel involved in running of the center. You may also want to involve children in doing safety checks.

- Teach children what to do in an emergency and where to get help.

Pre-packaged preschool safety curricula range from complete kits that come with audio-visuals and duplicate worksheets to suggestions for "do-it-yourself" educational aids and activities. The Injury Prevention Resource Center, located in the Department of Public Health, offers a variety of preschool curricula. SAFE DAYCARE includes specific preschool curricular suggestions on the topics of pedestrian safety, playground safety, passenger safety, and burns. (Please refer to Resources section of Appendices.)

Only you can select the type of safety curriculum that best fits the needs and philosophy of your center. Whatever you decide to do, remember that safety education is more than just a one-time activity, such as a film, or a talk by the community safety officer. Concepts should be reinforced through integration into other activities where safe behavior is rewarded.

Here are some ideas:

- Include poison prevention in nutrition education, by playing the "Good to Eat/Bad to Eat" game. Children can cut out pictures of medicines, household products, junk foods, and nutritional foods as shown in various magazines.

- Make a doll house from cardboard boxes. Children can use real or paper dolls to act out home hazards such as hot surfaces, poisonous products, toys left on stairs.

- Include messages about proper clothing for unsafe conditions into a lesson on weather and appropriate dress:

  - light colors at night or on dark rainy days;
  - dark colors on bright snowy days.

References

This chapter was prepared in large part by and reviewed by the staff of SCIPP.

It draws upon the extensive library of SCIPP's Injury Prevention Resource Center, as well as some of SCIPP's own research data. Readers wishing more extensive or detailed references should contact the Resource Center at (617) 727-1246. (See also the references to OFC regulations and sanitary code sections in Chapter 4.)

7 Transportation Safety

Introduction

Transportation is an important part of preschool programs. Whether you drive the children to and from their homes each day or have an occasional field trip, the cars or buses that you are using are still part of your center. Motor vehicle accidents represent the greatest threat to a child's life. You can reduce the chances of injury to staff and children during transport by:

- Being alert to potential dangers.
- Taking actions to eliminate or avoid these dangers.
- Knowing what to do when an emergency occurs.

This chapter will try to go beyond state law and OFC regulations to offer some ideas for setting up and maintaining a safe transportation system. Another key resource for day care providers is the Massachusetts Passenger Safety Program and Resource Center, located at the Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111. It can be reached at (617) 727-1246 or 1-800-CAR SAFE (toll-free).

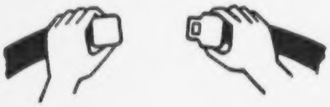
Staff, including the driver(s), parents, and children can all contribute to a safe transportation program. Parents *and* children need to understand the reasons for certain rules. Staff, especially, are responsible for enforcing these rules consistently. A written policy provides answers to frequent questions, and helps everyone understand his/her role.

A written policy that clearly states rules, responsibilities of children and staff, and emergency procedures is essential. The guidelines on the following pages provide an overview of the issues to be addressed in any transportation policy. These suggestions can be adapted easily to fit your individual program's needs. Figure 13 lists ten basic rules.

This chapter will not go into detail on the many aspects involved in establishing a comprehensive bus transportation system (daily

Figure 13

Ten Rules for Transportation Safety



1. All vehicles used to transport children should have federally approved safety seats and/or seat belts.

2. Each child should be in his/her own safety seat or belt. Two or more children should never be in the same belt. In a sudden stop or crash, having two children buckled together can result in serious injuries.

3. Vehicles that are used daily should be checked daily.

4. The driver should conduct a quick five-minute check that the vehicle is working well, and there is nothing in the vehicle that could harm the children.

5. Drivers should stay alert to changes in the vehicle while driving. Unusual odors, sounds, or vibrations can be warning signals for breakdown.

6. Neither children nor adults should be transported in the cargo area of a station wagon or van.

7. Children should never be left alone in a vehicle.

8. Sharp or heavy objects should be kept in the trunk. They can become deadly projectiles in a sudden stop or accident.

9. Young children should be loaded and unloaded only when pulled up to the curb, side of the road, or in a driveway.

10. Children should not put their arms or heads out of the vehicle windows.

inspection form, child transportation card, driver training). That information is provided in the manual Us In A Bus. If you do not have that resource, a special packet is available to you at no charge from the Massachusetts Passenger Safety Program.

Specifically, this chapter focuses on the following topics:

- Proper use of restraints
- Being prepared for emergencies
- When you carpool or use cars occasionally
- Auto passenger safety education

Proper Use of Child Car Restraints

In 1981, Massachusetts adopted the child passenger safety law requiring that all children under age five must be fastened in a properly adjusted car seat or seat belt while riding in a motor vehicle. Exemptions include:

- vehicles without seat belts
- vehicles with all seat belts and car seats in use
- vehicles for hire (taxi, limousines)
- children physically unable to use a car seat or seat belt

To be licensed by the Office for Children, certain additional standards are required:

- The licensee shall not allow the number of children riding in a center-owned, staff member's vehicle, or hired vehicle to exceed the number of seats.

- Suitable child restraints or seat belts are to be provided and must be used by each child, driver, and attendant. All child restraints must be crash tested and approved for use.

Although Massachusetts does not currently have a mandatory seat belt law for adults and children over 12 years of age, day care regulations require use by all occupants. Encourage children, staff, and parents to also "buckle-up" for all other travel as well.

Protecting child passengers involves more than simply placing them in a safety seat or seat belt. Child restraint devices have been proven to be highly effective in preventing death and injury to children. However, if safety restraints are not used properly, they cannot protect children and can cause harm. In order to install and use your particular car seat properly, read instructions carefully. Make an extra copy of the directions to keep on hand.

All staff who will be using car seats should be trained in their proper use. Before the training is completed, each staff member should demonstrate how to properly install and use the seat.

Car seats manufactured after January, 1981, must meet the Federal Motor Vehicle Safety Standard 213. While no particular car seat is considered "the best," you should make a selection based on a seat that:

- will fit securely and properly in your vehicle(s),
- will be used correctly on each ride.

Safety restraints are available in a range of sizes and styles, and are designed to be used by newborns through older preschoolers. (See Figure 14.) Test the seat in your car, van, or bus before purchasing to make sure it is right for your vehicle.

Problems with car seats should be reported to the National Highway Traffic Safety Administration via the toll-free number:

☎ 1-800-424-9393.

Remember that metal buckles on car seats or seat belts can get hot and cause serious burns. While not in use, cover car seats with a blanket or towel. Touch all metal pieces before putting a child into a seat or seat belt.

Being Prepared for Emergencies

Being prepared for transportation emergencies involves knowing what to do (e.g., first aid or evacuation) and having the necessary equipment and information immediately available.

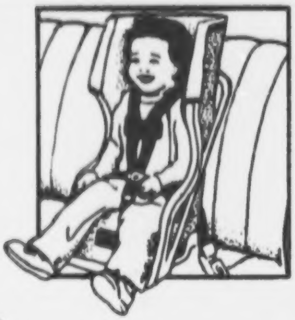
EMERGENCY PROCEDURES

Always expect the unexpected, no matter how efficient and safe your transportation system is. Parents, children, driver(s), and other center staff should all know what to do in an emergency. Drivers should be trained in the specific steps to follow under various emergency conditions.

Staff at the center should know what to do when they are notified of an emergency on the road, e.g., contacting parents or providing alternate transportation.

Parents should be reminded of emergency procedures annually, and must give accurate up-to-date information on how they can be

Figure 14
How to Use Car Safety Seats



There are three essential points to remember about restraining children:

- The child must be buckled properly into the restraint.
- The restraint must be correctly attached to the vehicle.
- The restraint must be facing in the appropriate direction.

INFANT SAFETY SEATS (Birth – 20 lbs.)

[redacted]

- *Infant safety seats must face the rear of the car.*
- Straps hold the infant in the safety seat.
- The safety seat is attached to the car by a safety belt.
- Safety seat should be used in the semi-reclined position.

TODDLER SAFETY SEATS (20 lbs. – 50 lbs.)

[redacted]

- Use only for children who can sit up by themselves.
- Safety seat should be facing forward and be used only in the upright position.
- Child is held in the safety seat by a harness, shield, or combination.
- The safety seat is attached to the car by a safety belt.
- If a top anchor strap is provided, it *must* be used.

BOOSTER SEAT (20 lbs. – 65 lbs.)

[redacted]

- Must be used with support for the upper body, e.g., mini-shield, harness, or the vehicle's lap/shoulder belt.
- An option to the safety belt for children who are under 4'6"(varies slightly by model), and have outgrown the height and weight specifications for the toddler seat.
- Effectiveness is improved when used with vehicle lap/shoulder belt (instead of lap belt only).
- Boosters with a tethered upper body harness are highly effective and more difficult to use. They are no longer commercially available, but many are still available secondhand.

SAFETY BELTS (Over 50 lbs)

[redacted]

- Use for children who are too tall or too heavy for safety seats.
- The lap belt should fit low and snugly across the child's hips.
- Use the shoulder belt only if it does not cross the child's face or neck.
- If the shoulder belt is not used, tuck it behind the child, not under his/her arm.
- If no safety seat is available, use seat belts for any child able to sit up alone.

contacted. If you use a bus, practice emergency evacuation drills with the children so they will be familiar with what they may be asked to do.

There are a number of questions regarding emergencies during travel which all staff should discuss and understand. They should also be part of your center's written policy. Involve parents and children in planning emergency procedures, because their problems and concerns in emergencies may differ from those of staff. The following are some issues of emergency procedures that you should discuss:

- how to evacuate the vehicle in case of an accident or breakdown
- how to assess injuries and provide first aid
- what staff at the center are to do
- how to explain the situation to the children and reassure them of their safety
- when to call for emergency support, e.g., police
- what to do in bad weather
- what to do when a child becomes ill or injured during transport

WHAT TO HAVE IN THE VEHICLE

The information and equipment listed below are helpful for both daily transportation activities and special field trips:

Information

Information about the children and the route can be kept in a three-ring notebook in the vehicle for easy access by the driver and other staff.

- Include a map of the route with estimated mileages and travel times, and the names and addresses of children on the route.
- Include an information/emergency card for each child that includes how to reach parents and emergency contacts and special medical or health information.
- Provide information on children with special needs, so that their ride will be as safe and comfortable as possible. Descriptions of the condition, behavior patterns, and warning signs for medical attention can be helpful in case of an emergency.

- List phone numbers of emergency services such as local police, fire station, hospital, and ambulance service, as well as the name and phone number of the center and a contact person there.

- Give copies of the transportation rules and procedures to parents. Rules will be easier to enforce if parents know and understand them.

Equipment

- First aid kit - list of suggested items can be found at the end of Chapter 8 (Figure 19).

- Emergency "toy chest" - songs, books, toys to help keep children occupied if stuck somewhere.

- Travel rope for children to hold onto for easy evacuation of any vehicle or for walks from the vehicle to a safe place.

- Fire extinguisher, extra water, and appropriate tools for minor repairs in case of breakdown.

Emergency situations need to be handled calmly and efficiently, with constant attention to the children's fears, concerns, and safety.

Field Trips/Carpools

A well organized transportation system is important even if you do not transport children regularly. Special trips mean special circumstances. First of all, drivers may be traveling over an unfamiliar route, or transporting children who may not ordinarily ride with them. Drivers may be sharing responsibility with volunteers who are themselves in a new situation. Finally, the children may be overexcited or overtired from a new or long trip, or may be frightened because they are going to an unfamiliar place. The following suggestions (adapted from Us in a Bus) can help staff transport children safely during special trips:

- When your destination is known in advance, review the route mentally or with a map if the distance is great; or, practice the route if you have time and the vehicle is available.

- Make sure that you have an authorization and/or list for every child and adult who will be traveling. Each child should have parental or guardian permission for each trip. Check your insurance coverage for carpools.

- Make sure both the driver and other adults riding the bus know who is responsible for responding to discipline issues with the children: e.g., parent volunteers, staff, or bus driver. Make sure that you tell children who is in charge.

- Make sure that children and all adults are appropriately restrained or wearing seat belts when riding in the car.

- Never have more passengers, children, or adults than seat belts.

- Soft books or toys, songs, and conversation help keep the children quiet while their driver concentrates.

- Use this time to talk about rules for safe riding or other important concepts.

- If children become unruly, stop and pull off the road to calm them down. *Do not try to drive and discipline at the same time.*

- Make sure that all passengers know what time they are supposed to return to the vehicle.

- If more than one vehicle is involved in the trip, it should be clear that all passengers know in which vehicle they are to ride for the return trip.

- On field trips, make sure that no child enters the vehicle alone or plays on the vehicle while the others are visiting the site. *Never leave children alone in the vehicle.*

- Use a trip sheet to record destination, mileage, times of departure and return, and a list of passengers. For large field trips, the latter is particularly important.

- Be sure that all members of the carpools understand and agree to these guidelines.

Auto Passenger Safety Education

■ CHILDREN

Preschoolers are old enough to learn simple concepts of auto safety. Consistent reinforcement of safe behaviors helps children remember them in later years.

There are five major passenger safety messages to emphasize with children (and parents!):

1. Everyone in the car should buckle up - including drivers and passengers in the front and back seats.
2. Seat belts go over the hip, not the stomach.
3. The back seat is the best seat for child passengers.
4. Good passengers buckle up and ride quietly.
5. Seat belts or safety seats should be worn on every ride, no matter how short the trip.

Make "pretend" cars with cardboard boxes chairs or seats, and seat belts from junk yards. Play games such as "Simon Says", using seat belts, and entering/leaving vehicles correctly. These are also fun for role playing and dramatic play activities. Invite the safety officer from your community to come and talk about traffic safety.

Concepts can be presented simply, using songs, stories, art work, audio-visuals, and a variety of props. There are many materials available for your use in teaching passenger safety from the Massachusetts Passenger Safety Program. For example:

1. "We Love You Buckle Up" is a comprehensive packet containing a teacher guide, story book, poster, sample letter to parents, stickers, safety seat brochure, and list of additional resources.
2. "Riding With Buckle Bear" is another age-appropriate kit of sample activities and slide/tape presentation.
3. "Buckle-Up Bear" Coloring Books and stickers in English and Spanish produced by the Massachusetts Department of Public Health are also available at no cost.
4. Buckle Bear costume is a full-sized bear suit with seatbelt available for loan.

PARENTS

It is important to involve parents in educational activities; they can reinforce concepts you present in the classroom. Keep them informed of the topics that you cover via letters, parent education meetings, etc. You can also send activities home that parents and children can work on together (e.g., counting the number of seat belts in the car).

Focus on three main issues when working with parents:

1. The importance of always using child safety seats and safety belts.

2. How to select a suitable child safety seat.

3. How to use child safety seats and seat belts correctly.

References

This chapter was prepared in large part by and reviewed by staff from SCIPP and the Massachusetts Passenger Safety Program (MPSP). It draws upon the extensive library of the Massachusetts Passenger Safety Resource Center. Readers wishing more extensive or detailed references should contact MPSP at (617) 727-1246 or 1-800-CAR-SAFE (toll-free). The source specifically mentioned in the text is given below.

Project R.E.A.C.H. (Regional Education and Assistance Collaborative for Head Start). Us In A Bus: A Transportation Manual for Head Start Programs. Newton, MA: Educational Development Center, 1984. [Copies can be ordered through MPSP.]

8 Emergencies/First Aid

Introduction

No matter how careful and safety-conscious you are, there will be times when emergencies occur.

A child falls from the climber on your playground...you suddenly lose your electrical power during a winter storm...you smell gas in the center...a child starts to choke during snack time. Would you know what to do?

Situations such as these show how essential a comprehensive written policy is to the smooth functioning of your program. Your center's policy needs to answer questions such as:

- Who will give first aid?
- Who will take the attendance list if the building needs to be evacuated?
- What will you do if some of the children panic and refuse to leave the building?

Your policy should clearly state the roles and responsibilities of the children and each staff member in an emergency. Parents, too, need to be informed of your center's emergency policy and their roles in it.

Be Prepared for Emergencies

This chapter focuses on the following topics:

- Be Prepared for Emergencies
- Emergency Evacuation Plans
- First Aid
- First Aid Education

The following are some general guidelines for handling emergencies. They can be easily adapted to fit your center's needs.

- Staff should be certified in First Aid and CPR (Cardio-pulmonary resuscitation). At least one certified staff person should be in the center at all times. Certification should be renewed every year.
- Keep your first aid kit where it can be easily reached in an emergency, but away from children.
- Check your kit regularly to make sure supplies are adequate.
- Keep list of emergency phone numbers and procedures near all phones for easy, quick reference.
- Be sure you know how to reach each child's parent(s) at all times.
- Have current, signed emergency transportation permission forms for all children.

EMERGENCY PROCEDURES

In the event of an emergency, there are two important things to remember:

KEEP CALM

ACT QUICKLY

If you panic, it is likely the children will panic, too!

Different programs may have different policies for emergencies, based on their size, location, and the ages of the children. Figure 15 presents an outline of procedures you can adapt to fit your own needs in case of *serious* medical emergencies.

Hospitals and emergency rooms will NOT give emergency treatment to any minor child, except in a life-threatening situation, without parental informed consent at the time of treatment. Parents *can* give you standing permission (i.e., on file at the center) to transport the child to an emergency treatment center; see Figure 16 for a sample permission form.

According to OFC regulations, centers must notify parents of any first aid given and of any injuries or illness that needed more care than first aid. The center should have a standardized form to report all injuries that require first aid or other emergency procedures; see Figure 17 for a sample Injury Report Form. One copy should be given to the parent(s) and one filed in the child's folder. Some injuries or incidents must also be reported to the Office for Children as well: the death of any child while in care, or any injury that occurs while in care and which then requires inpatient hospitalization overnight or longer.

Centers should also maintain a master listing or injury log so that patterns of injury or other incidents can be monitored over time and safety at the center improved.

GETTING HELP

Most of us assume that we can use a telephone to call for help. Usually we can, but it is important to think about alternatives in case a working telephone is not available. Know the locations of nearby pay phones, fire alarm boxes, or places you could go for help. Make sure that the phone in your center can be reached easily and that it is never locked away.

Usually you can reach emergency assistance by dialing 911. If 911 is not available in your area, you should be familiar with the numbers for police, fire and ambulance. You can call the operator, but this is a slower way to get help.

Keep an emergency phone list posted in an easily readable spot by every telephone. A sample list is provided in Figure 18. You should include your address, description of the building, and directions to it from a major road - these may be hard to remember in a crisis situation. Local emergency numbers can be found on the inside front cover of your phone book.

HOW TO LEARN MORE ABOUT "HELPERS"

Short of getting hurt and meeting all these helpers in this way, most people know very little about their local emergency medical services. This does not have to be true for you. In order to be better at first aid, you should be familiar with the ambulance and emergency room in your area. Here are some questions you should try to answer:

- Who answers the emergency phone? (Police, fire, ambulance, dispatcher?)

- What steps does the dispatcher have to take before sending the ambulance? (Call another dispatcher? Call Emergency Medical Technicians?)

- Who provides the ambulance service? (Police, fire, volunteer, private companies, another town?)

- How far do they have to travel to get to me? Where is the station?

- How long will it usually take them to get to me?

- Where are the nearest emergency rooms?

A final note on help: Get to know your local helpers *before* you need them in a crisis. Most ambulance services are happy to show visitors (including preschoolers) around their office, and some will even come visit you if asked. Emergency rooms are harder to tour, but you can at least visit the waiting area and become familiar with how to get checked in. Familiarity with helpers now will come in handy when you need them later.

THE FIRST AID KIT

At least one first aid kit should be maintained at the center at all times. A kit also should be available whenever and wherever children are in care (e.g., on field trips, walks, etc.). In particular, you may want one easily reachable for each high risk area such as the kitchen and playground. The kit may be in any lightweight and convenient container - a lunch box, handbag, or shopping bag. *The kit must be kept out of the reach of children.* Suggested contents of a first aid kit are listed in Figure 19. Assign someone on your staff to inspect the kit monthly to be sure that the kit is complete. Keep a list of the contents you maintain in your kit and a record of the monthly inspections.

Emergency Evacuation Plans

EMERGENCIES THAT REQUIRE EVACUATION

Planning, practice, and preparation are the essential ingredients of a successful evacuation plan. There should be a written procedure which includes routes, assignments for all staff, and location of nearest alarm which alerts the Fire Department.

In the event of fire, explosion, or other similar emergency, saving lives is the first priority. Saving property should be considered only when all lives are safe.

When there is an emergency which requires evacuation, the following steps should be taken:

- Sound alarm - notify everyone in building.

- Evacuate. Use exit routes previously marked and practiced in drills. Plan and practice using alternate routes.

- Eliminate drafts - someone should be responsible to close all doors and windows.

- Take a head count - make sure everyone is safely out of the building.

- Call Fire Department after leaving the building - call from nearest alarm box or phone if building alarm is not connected to the Fire Department.

Emergency information for children and staff should be available at all times. Assign responsibility to a specific person who will have this information on hand in an emergency, on trips, and in the event of program site evacuation so that family members can be contacted. Emergency contacts named by parents should be updated at least every six months and verified by phone or mail.

Know where you are going to stay if the building has to be evacuated. Families must know where to look for their children so they will not rush into an evacuated building searching for their child. Prearrange an emergency shelter where you are going to stay and inform parents by letter.

Record daily attendance of staff and children. Designate a staff member to carry the list out of the building so that complete evacuation is assured.

Post emergency telephone numbers (police, fire rescue or central emergency code, and poison control) beside every phone. All individuals using the building should be familiar with these numbers and the procedures to be used in an emergency.

Plan two exit routes from every area of the building. Post emergency evacuation exit instructions in every room where they can be seen easily.

Have unannounced evacuation drills monthly. Evacuation should include use of alternative exit routes in case of blockage. Time should vary to include all activities, and when the fewest adults are at the center, e.g., at nap time.

Maintain logs of evacuation drills for on-site inspection and review by the building inspector. *For most buildings, evacuation in less than two minutes is possible.* Fire-resistant exit routes in large buildings are usually required to provide enough time to exit safely.

Many fire and police departments maintain public education divisions and will arrange on-site visits to help program staff make appropriate emergency plans.

FIRE PREPAREDNESS

- Keep the phone number of the fire department and heating service company by your telephones.
- Post a diagram showing the main shut-off switches for electricity, gas, and water.
- Test fire and smoke alarms at least once per month to see that they are working. Have fire extinguishers inspected annually.
- Place fire extinguishers where they can be reached easily.
- Post diagrams of exits and escape routes in each room. Mark exits clearly, and do not block them with furniture, toys or other objects.
- Practice leaving the building with the children once per month so that they know the sound of the alarm and know where to go.
- Include fire and burn prevention in children's curriculum.

Knowing when and when not to use a fire extinguisher is an important part of fire preparedness. Use your extinguisher only if:

- You are nearby when a fire starts or the fire is discovered in its early stages.
- Other staff *get all children out of the building and call the fire department.*
- The fire is small (confined to its origin in a wastepaper basket, cushion, or small appliance).
- You can fight it with your back to an exit.
- Your extinguisher is in working order and you know how to use it:
  - Stand back about eight feet.
  - Aim at the base of the fire, not the flames or smoke.
  - Squeeze or press the lever while sweeping from side to side.
- You know enough to get out fast if your effort is failing.

If the fire spreads beyond the spot where it started, or if the fire could block your exit, don't try to fight it. If you have the slightest doubt about whether to fight or not to fight -- don't. Get out and call the fire department.

WHAT DO YOU DO IN COMPLICATED SITUATIONS?

To calm a group of panicked children:

Remove them from the scene (if a child has been injured), and reassure them. Explain simply and carefully what has happened and what will happen. Answer their questions truthfully. Redirect their attention - a game or quiet activity. Most importantly: *STAY CALM.* If you panic, the children will panic, too. If you need to evacuate the building, and children are frightened, have them hold each other's hands. Human touch is very reassuring in scary situations.

To get non-ambulatory children out of the building:

Have available specially made aprons, smocks, or carriers of fire-resistant material with large pockets to carry two or three infants at the same time. Keep these in the infant area.

For toddlers or severely handicapped children, a large wagon can be used to quickly transport them outdoors (if your building has ramps) or at least to the door where someone else can take them.

To get a child who is too scared to move to leave the building:

Press gently on the back of the knees to push him/her forward or hold their hands with one of your arms across their back. Having everyone join hands can also help the child feel less frightened.

First Aid

First aid is the immediate care for persons who are injured or ill. All group day care programs are required by the Office for Children to train staff in first aid procedures. This manual therefore will not go into detail about first aid. It is assumed that every center has a first aid guide book at the center at all times; if you do not, you should get one immediately! References for helpful first aid resources are given in the Appendices.

The information included in this section is based on the Childhood Emergency Sourcebook developed by the Preschool Enrichment Team. (See References.) Only basic first aid concepts are included:

- General Guidelines
- Assessment of the Injury
- Next Steps
- Poison Emergencies

GENERAL GUIDELINES

Emergency situations are always upsetting. Being upset makes it difficult to think clearly. In these situations, it is particularly important to have a system to help staff to react quickly and correctly. First aid is a way of managing an illness or injury until further medical care can be obtained, if necessary. When giving first aid, there are two ways you can harm someone. The first is by not treating an injury and the second is by further damaging an injury that is already there.

There are two very important rules of first aid:

DO NO HARM.

NEVER MOVE A HURT CHILD EXCEPT TO SAVE A LIFE.

It is absolutely critical that the first aid provider remain calm and reassure the victim. A calm attitude will allow the provider to think clearly and act appropriately. Later, when the situation is taken care of, all involved (including other children) will need the opportunity to work through their feelings about what happened.

At the time of the emergency injury or illness, other adults should remove the other children to an area away from the victim. This will clear the area to carry out the necessary first aid and create a calmer atmosphere for the other children to be reassured.

ASSESSMENT OF THE INJURY

Primary Survey

The PRIMARY SURVEY is the first thing to do when helping a hurt child. There are six steps to a good primary survey and altogether they take about 45 seconds to do.

1. *Look Around.* Ask yourself. Am I prepared? In control? What happened? When? Is there danger? Remember, first do no harm. Never move a child except to save a life.

2. *Check the level of consciousness.* Is the child conscious? Shout the name if s/he does not seem to respond to questions.

3. *Check the airway.* Is the airway clear? Move the jaw/tongue up. Do not move the neck if there is any chance of injury. Wipe anything extra out of the mouth.

4. *Check breathing.* Is the child breathing? Look, listen, and feel for 15 seconds. If the child is not breathing, give four quick breaths.

5. *Check pulse.* Is there a pulse? Check neck pulse in adults and children, upper arm pulse in babies.

   Check for 5 seconds. If no pulse, start C.P.R.

6. *Get help.* Have someone else call an ambulance.

Remember, always ask yourself these four basic questions:

a. Is the child conscious?
b. Does the child have clear air passages?
c. Is the child breathing?
d. Does the child have a pulse?

You should *always* know the answers to these questions, not just for the first few minutes, but during the *whole* time you are helping someone. Vital functions can change, and since they are essential to life, they must be watched closely. If a child is fairly well (awake and talking or crying), then you can continue to check vital functions by simply watching and talking with him/her. When the child is unconscious or seriously hurt, you need to spend more time actually checking the vital functions. Of course, if any one of the vital functions is not working properly, you must immediately try to correct the problem, get help if necessary and then spend most of your time continuing to check the child's progress.

Secondary Survey

A SECONDARY SURVEY comes after completing the primary survey to check for life-threatening problems. It is a head-to-toe search for anything unusual which might help identify the cause of the child's problem.

The goal of a secondary survey is to thoroughly but *quickly* go over the whole body, starting with the most important area (the head) and working toward less important areas. As you move along, you should touch and look at as much of the body surface as possible *without moving the child.* You are trying to find anything which either feels or looks unusual to you, or which causes the child discomfort or pain. Anything you find, even if you don't understand it, may be helpful to ambulance or hospital personnel who see the child later. You can compare one side with the other to check what you find.

This is a step-by-step summary of the secondary survey:

HEAD:

Eyes: Pull the eyelids open and look at the pupils (the dark circle in the middle of the eye). They should be about the same size, and they should get smaller when light hits them. The eyes should be looking in the same direction. Eye problems can be a sign of eye injury, poisoning, or brain injury.

Ears: Look for blood or clear fluid draining from the ears. Either might be a sign of skull or brain injury. (Don't be fooled by tears that have run into the ears - they are normal!)

Scalp: Feel as much of the scalp as possible without moving the child's head. Check for bleeding, bumps or dents, or anything else unusual.

Nose and Mouth: Quickly check these for bleeding and tooth injury.

NECK: Recheck the neck pulse and breathing. Feel the neck *without moving the child's head,* for bleeding, swelling, irregularities of the neck bones, or stiff muscles.

CHEST: Feel the whole chest. Run your fingers along both collarbones, breastbone, and ribs to check for swelling, unusual position or motion, or pain which might indicate a broken bone.

BACK: Slide your hands under the back, checking for bleeding, broken bones or pain. You should be able to do this gently and feel most of the back without moving the child.

ABDOMEN: Feel the child's abdomen gently, checking for bleeding or pain. Notice whether the abdominal muscles are tight or relaxed. If the child is unconscious and his/her other muscles are relaxed, tight abdominal muscles may indicate an injury or illness inside the abdomen.

ARMS: Starting with the shoulder, feel carefully along the whole arm. Check for bleeding, swelling, pain, or any unusual shape or motion of the bones. When you get to the wrist, check the pulse on the thumb side. If it isn't strong, go back and check the neck pulse. Feel the hand bones, and check the temperature of the skin. Cold hands and/or purple fingernails may indicate poor circulation. Be sure to check both arms.

HIPS AND LEGS: As with the arms, start at the hips and work your way down. When you reach the knees, measure across to see if they are the same distance from the hips. A difference in length may indicate a break or dislocation. Continue down from the knees to the feet. If they are easy to get to (don't pull off tight boots!), look at the toenails and check the temperature of the feet just as you did with the hands.

NEXT STEPS

After assessing the injury or illness, decide if you must continue with the emergency procedures outlined in your center's health policies. Be sure that *every* staff member knows what your policy is. If you have any doubt as to how serious the problem is, get help. If the injury is not serious, administer the appropriate specific first aid.

For all serious emergencies and whenever first aid is given, complete an injury report within 24 hours; give one copy to parents and file one in the child's folder. Enter the information into the injury log also. If possible, give the report to the parents the same day as the incident.

POISON EMERGENCIES

We usually think of poisoning as swallowing a toxic substance. However, chemicals in the eyes or on the skin, and the breathing of toxic fumes are also considered poison emergencies.

- In all cases of poisoning *always* call the Massachusetts Poison Control Center. The center is open 24 hours a day. You should have the toll-free number(s) on or near ALL phones.

MASSACHUSETTS POISON INFORMATION CENTER

GREATER BOSTON AREA: 232-2120

OTHER MASSACHUSETTS AREAS: 1-800-682-9211

When calling the Poison Center, be sure that you give specific information about:

1. The product the child was exposed to (have container with you when you call)
2. The amount
3. The time of exposure

- Include *syrup of ipecac* in your first aid kit. Swallowing ipecac is the most effective way to cause vomiting.

Do NOT use ipecac unless told to do by the Poison Center or physician. Some poisons, such as drain cleaner or lye, can cause serious damage to the esophagus if vomited.

- Do NOT rely on antidote charts or first aid information on product labels. They are sometimes or out of date and can sometimes cause additional damage. *Call the Poison Center first.*

First Aid Education

STAFF

The Office for Children requires centers to train all staff in basic first aid procedures, including choking, seizures, and resuscitation. This training should be done at least yearly, or more often if necessary to train new staff. The first aid training should be geared toward early childhood and the unique needs of day care providers. Ideally, it should include a developmental approach to children and injury prevention as well as how to handle emergencies appropriately from both a medical and psychological viewpoint. All staff must know your center's specific policies for emergencies in addition to basic first aid.

CHILDREN

Children should know how and from whom to get help. It is helpful to teach children several basic concepts:

- Tell an adult right away if something is wrong (someone is hurt or sick).
- Some things are dangerous (e.g., poisons, matches, tiny objects in the mouth).
- A person who is very hurt or sick may need to be alone with a helper.
- Follow all safety rules.

Older preschool children also can be taught about basic care concepts such as: cuts need to be cleaned with soap and water, direct pressure helps stop bleeding, burns should be treated with cold water. This information may help children to be more cooperative, if they can understand why certain first aid procedures are necessary.

PARENTS

It is always helpful to help parents refresh their first aid skills. You may consider inviting parents to your staff training or having a special meeting to review home first aid procedures. You might want to put brief articles in your newsletter, if you have one. Keep parents informed when you know about community education programs. First aid resources are a great addition to a parent lending library, too.

Figure 15

Emergency Procedures

EMERGENCY

1. Remain calm. Reassure the victim.

2. Stay at the scene and give help until the person assigned to handle emergencies arrives.

3. Send word to the person who handles emergencies at the center. This person will take charge of the emergency, assess the situation, and give any further first aid, as needed.

4. Do not move a severely injured or ill person except to save a life.

5. If necessary, phone for help. Give all the important information slowly and clearly. To make sure that you have given all the necessary information, wait for the other party to hang up first. Arrange for transportation of the injured person by ambulance or other such vehicle, if necessary. Do not drive unless accompanied by another adult. Bring your Emergency Transportaton Permission Form with you.

6. Do not give aspirin or other medications (unless authorized by the Poison Center for poisonings or physician for other illnesses).

7. Notify parent(s) of the emergency and agree on a course of action with the parent(s).

8. If parent cannot be reached, notify parent's emergency contact person and call the physician shown on the child's Emergency Transportation Permission form.

9. A responsible individual from the center should stay with the child until parents take charge.

10. Fill out accident report within 24 hours. File in the child's folder. Give parent(s) a copy, preferably that day. Note injury information in central injury log.

Figure 16
Sample Emergency Transportation Permission Form

I understand that no emergency treatment will be given without parental consent except in a life-threatening situation. Since informed consent must be given at the time of the incident, I understand that I must leave numbers where I (or my spouse or a responsible adult designated by me) may be reached daily if the numbers below do not apply for that day.

In case of a medical emergency while my child is attending ____________ ________________________________, I understand that the following procedure will be followed:

1. The center will contact parent(s):

   Mother can be reached at (Tel.)____________ or ____________.

   Father can be reached at (Tel.)_____________or ____________.

2. If neither is available, the center will contact these emergency persons:

   Name:_____________________can be reached at _______________.

   Name:_____________________can be reached at _______________.

   Name:_____________________can be reached at _______________.

3. The center will arrange for emergency transportation to the nearest emergency medical facility, if necessary. At no time will a staff member drive with my child unless accompanied by another adult. My child will be transported by an ambulance or other such vehicle when necessary.

4. The center also will contact my child's physician___________________

   ________________ who can be reached at ____________________________.

I hereby authorize the center to follow this procedure.

Parent's Signature:_________________________________Date:______________

Figure 17

Sample Injury Report Form

CHILD'S NAME: ____________________

DATE OF INJURY: ____________________ TIME OF INJURY: __________

WITNESS: ____________________

PARENTS NOTIFIED BY: ____________________ TIME OF REPORT: __________

LOCATION OF INJURY: ____________________

EQUIPMENT/PRODUCT (IF ANY) INVOLVED: ____________________

DESCRIPTION OF INJURY; SPECIFY BODY PART(S) INVOLVED: ____________________

DESCRIPTION OF HOW INJURY OCCURRED: ____________________

FIRST AID OR MEDICAL CARE REQUIRED (Describe actions taken by Center):

WHERE ELSE CHILD RECEIVED TREATMENT (Specify hospital, clinic, or physician):

DIAGNOSIS/FOLLOW-UP PLAN: ____________________

SIGNATURE OF STAFF MEMBER: ____________________ DATE: __________

SIGNATURE OF PARENT: ____________________ DATE: __________

SUBMIT WITHIN 24 HOURS OF ACCIDENT

File in Child's Folder.
Give Copy to Parent.
Enter into Injury Log.

Figure 18
Sample Emergency Phone List

This phone is located at: ______________________

Phone Number: ______________________

Directions

e.g., 2nd floor rear of the old Washington
Elementary School building at the
intersection of Main and South Streets

Emergency Numbers

Police:
Fire:
Ambulance:
Nearest Emergency Facility:

Important Numbers

Poison Control Center:
Health Consultant:
Child Abuse Hot Line:
Local Department of Social Services:
Taxi:

Electric Company:
Gas Company:
Heating Company:
Plumber:

(At home you should include work numbers for any adult who might need to be reached in a hurry.)

ALWAYS GIVE THIS INFORMATION IN EMERGENCIES

1. Name
2. Nature of emergency
3. Telephone number
4. Address
5. Easy directions
6. Exact location of injured person (e.g., backyard behind parking lot)

OPTIONAL INFORMATION

7. Help already given
8. Ways to make it easier to find you (e.g., standing in front of building, red flag)

DO NOT HANG UP BEFORE THE OTHER PERSON HANGS UP

Figure 19
First Aid Kit List

The following is a list of items which should be included in a basic home or preschool first aid kit:

- A quick-reference first aid manual, note cards and pen
- Disposable latex gloves (for blood spills)
- Thermometer
- Flashlight
- Blunt-tip scissors
- Tweezers
- Instant cool pack
- 10 4x4" gauze pads
- 10 2x2" gauze pads
- 1 roll 4" flexible gauze bandage ("Kling")
- 1 roll 2" flexible gauze bandage ("Kling")
- 25 1" and 25 assorted small "Band-Aids"
- 1 roll 1" bandage tape
- 2 triangular muslin bandages
- Syrup of Ipecac (at least 10 1-oz. bottles for centers)
- Packages of sugar or honey (for diabetes)
- With the kit, a large clean container (for use in flushing eyes)
- In your field trip kit:
  - some coins for pay phones
  - soap for washing wounds
  - cleansing pads.

References

American Red Cross of Massachusetts Bay. Health and Safety for Infants and Children. Boston, MA: American Red Cross, 1986.

National Safety Council. Home Fire Extinguishers. Home Safety Newsletter, January-February, 1985.

University of Illinois at Chicago, School of Public Health. Guidelines of Good Health in Illinois Day Care. (Schutz, C. E. and Belda, M., Eds.) Illinois Department of Public Health, 1985.

Williams, K. (in collaboration with the Preschool Enrichment Team, Inc.). Childhood Emergency Sourcebook. Holyoke, MA: Preschool Enrichment Team, Inc., 1985.

Introduction

Health is defined by the World Health Organization as "...a state of complete physical, mental, and social *well-being* and not merely the absence of disease or infirmity." This total state of "wellness" is affected by the interrelationship of each area of development. That is, the child who is ill, overtired, hungry, or poorly fed cannot function well and may become sleepy, cranky, or inattentive. The child who has an undetected medical condition or who is neglected may become depressed or withdrawn. The child with a physical problem may develop emotional or learning problems; likewise, the child who has emotional upsets may develop physical symptoms as a result of eating and/or sleeping disturbances, and so on. Furthermore, health is everchanging, particularly during preschool years when change itself is continual.

Adults' health also affects their state of well-being. Adults who are ill may not be able to function well in their jobs; they may become overtired, short-tempered, or weakened. Their personality, or other health habits such as eating and sleeping, may be affected as well. Adults, like children, require good preventive health care to keep well and function optimally.

A child's health status can be assessed from a variety of sources, including health histories, observations, screening tests, and medical examinations. As a staff member of an early childhood program, you are a member of a health team which provides these assessments. You are, in fact, providing an essential part of a comprehensive picture of a child's development.

The day care health program must be kept in perspective. Parents should be reminded that they have the responsibility to promote their child's health. Knowledge about health can relieve many parents' fears and their unrealistic expectations of doctors and nurses. Knowledge will help the family understand how to use (and not misuse) the system, prevent illness, and promote the health and well-being of the child and family.

Dental health is an essential part of good preventive health care. Dental disease is a very common problem among all ages, yet much of this dental disease is preventable by learning good dental health habits and getting regular dental care from the age of three through adulthood.

This section will discuss basic concerns of preventive health care. The following chapters are included in this section:

- Chapter 9: Preventive Child Health Services
- Chapter 10: Adult Health in Day Care
- Chapter 11: Dental Health

Throughout this section, the following major concepts are highlighted:

1. Day care staff are members of the preventive health team who aim to keep children well.

2. Regularly scheduled health visits, including health screenings, are essential to maintain children's health.

3. Health is assessed by the "health team" based on information from health histories, health observations, screening tests, and medical examinations.

4. Adults must take care of their own health needs and specific health issues which relate to day care.

5. Dental health is an important part of general preventive health care.

9 Preventive Child Health Care

Introduction

WHY IS PREVENTIVE CARE IMPORTANT?

Preschool children are at risk for developing a number of health problems -- poor hearing or vision, lead poisoning, developmental delays, injuries, etc. Preventive care is aimed at keeping children well, rather than treating them only when sick. Comprehensive preventive health care has a number of goals:

- To detect a medical condition that may not be easily recognized but needs medical attention, such as fluid in the ear, anemia, or "lazy eye." Often early identification and treatment of such problems cure them, while a delay in attention will result in more or permanent damage.

- To identify children who may be at high risk for developing certain diseases due to heredity, family health habits, or their environment.

- To identify and follow signs that could mean future health problems, such as growth patterns, behavior, or developmental delays.

- To evaluate the effectiveness of past or current treatment such as tubes in ears, antibiotics, or patching an eye.

The goals of well-child visits may be described as follows:

1. Health promotion -- counseling, education, anticipatory guidance (for the future)

2. Specific preventive measures such as immunizations

3. Identification of diseases without symptoms by screenings such as vision, hearing, lead poisoning, tuberculin testing

4. Early detection and treatment of illnesses with current symptoms (e.g., strep throat) to prevent complications

5. Prevention of disability from chronic diseases

It is crucial that children be seen regularly by health care providers to ensure that these goals are met. In Massachusetts, Project Good Health, a Medicaid program, has developed a protocol (recommended schedule) for preventive health care for young children in collaboration with physicians (see Figure 20). This schedule is appropriate for *all* children, not just those whose families use Medicaid.

FINDING HEALTH CARE SERVICES

Sometimes, poor families find it difficult to obtain good primary health care. There is an excellent resource in Massachusetts called Project Good Health which is available to children who are eligible for Medicaid. This service can help families locate comprehensive pediatric care and ensure that complete examinations are conducted at appropriate intervals. Please refer to Figure 21 for more information about Project Good Health.

HOW IS HEALTH ASSESSED?

Health is assessed by a variety of individuals, each with his/her unique skills and experience with the child. This "health team" is usually informally coordinated by the physician, and it is made up of the parents, teachers, nurses, and other health specialists as necessary, such as child psychologists, physical therapists or allergists, and any others who have an ongoing relationship with the child. See Appendix 7 for descriptions of typical health team members. Each person observes and interacts with the child and has a special opinion to offer about growth, development, and overall health. This information should be shared with the "team leader" (usually the physician) to provide a comprehensive picture of the child.

The assessment process is based on information from a variety of sources: health histories, health observations by the "health team," screening tests, and medical examinations.

Health assessment and follow-up care are often separated into three categories: screening, diagnosis, and treatment. You will hear these terms often, so it is important to be familiar with them.

Figure 20

Recommended Schedule for Preventive Health Care

Birth to Six Years

X = MUST BE DONE AT THIS AGE
●--● = MUST BE DONE DURING ONE OF SPANNED AGES

	New-Born	2-6 wks	8-10 wks	4 mos	6 mos	9 mos	1 yr	15 mos	20 mos	2 yr	30 mos	3 yrs	4 yrs	5 yrs	6 yrs
Newborn Initial History and Physical Exam	X														
Newborn Discharge History and Exam	X														
Health or Interval History		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Developmental Assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nutritional Assessment		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Health Education and Counseling (As Required)															
Comprehensive Physical Exam		X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hearing (Gross)		X	X	X	X	X	X	X	X	X	X	X			
Vision (Gross)		X	X	X	X	X	X	X	X	X	X	X			
Hearing (Audiometry)													●------	●	
Vision (Snellen)													●------	●	X
Blood Pressure												X	X	X	X
Hematocrit/Hemoglobin		●------	------	------	------	------	●		X						
EP or Blood Lead							X		X		X		X		
Urinary Dip Stick													●------	------	●
Urinalysis													●------	------	●
Urine Culture (If Indicated)															
TB Test							X						●------	------	●
Cholesterol (If history indicates need)														X	

Source: Project Good Health, Medicaid Division, Massachusetts Department of Public Welfare.

Figure 21
Project Good Health

1. *What is PGH?*

Project Good Health (PGH) is the name the Massachusetts Department of Public Welfare has given to the federally mandated Medicaid program EPSDT (Early and Periodic Screening, Diagnosis and Treatment). The primary objective of this program is to link Medicaid-eligible children and young adults under 21 years of age to sources of comprehensive health care. The program stresses the importance of receiving regular medical and dental examinations, as well as timely treatment for health problems.

2. *What is the PGH Protocol Schedule?*

Project Good Health, in conjunction with the Massachusetts Chapter of the American Academy of Pediatrics, has developed a comprehensive schedule of health screening and immunizations for children from birth to 21 years of age. This schedule details the procedures appropriate for each age level.

3. *Who is a PGH Provider?*

PGH providers are Medicaid physicians and community health centers who agree to follow the PGH protocol when performing routine health assessments and to bill for these services using a PGH claim form. Physicians and health centers are paid at a higher rate for their participation in this program. Participation in this program is voluntary.

4. *Who is eligible for PGH services?*

Children and young adults under the age of 21 who are eligible for Medicaid benefits. The program is voluntary.

5. *How do Medicaid recipients benefit from PGH?*

Participants receive regular health check-ups. They receive reminders when it is time to have another examination. In addition, the PGH automated tracking system enables the PGH field staff to monitor services to ensure that PGH participants receive necessary follow-up and treatment.

6. *How can you find PGH workers?*

They are located in 34 local welfare offices throughout the state. They provide information about preventive health practices to help the recipient understand the importance of scheduling regular examinations, and they directly assist recipients in obtaining these preventive health services.

SCREENING is the use of quick, inexpensive, and simple procedures to sort out the apparently healthy from those who may have an abnormality.

Health screening uses laboratory and other procedures to gather information about a child's health. If a specific test result falls within the "normal" range, nothing further is required. If a screening result does not fall within the normal range, it is called positive (that is, it could be atypical or abnormal). *Positive screening results identify those conditions which need further diagnosis and possible treatment.* Screening results are classified as:

Normal (negative) -- Apparently healthy; no action needed.
Suspect -- Possibly at risk; test again.
Atypical/Abnormal (positive) -- At risk; referral or diagnosis needed.

DIAGNOSIS is finding out if there is in fact a health problem and, if so, what it is.

When making a diagnosis a physician or other health professional may use health histories, dietary information, laboratory test results, family/teacher/staff observations, x-rays, physical and psychological examinations, etc. A diagnosis helps in planning treatment specific to the individual patient's problems.

TREATMENT is management and care designed to control, minimize, correct, or cure a disease or abnormality (e.g., eyeglasses, fillings for dental caries, therapy for a child with an emotional problem.)

Treatment is the key to an effective program. Without it, screening and diagnosis are meaningless. Treatment may be needed to establish or regain normal health, to stop further progression of health problems, or to prevent their happening again.

The remainder of this chapter will focus on the following topics:

- Health Histories
- Health Observations
- Major Health Screenings
- Medical Examinations

Health Histories

Health histories provide important information about the child's prior health experiences and risks for future disease. The family health history may predict what illnesses the child may inherit or develop. The physician will take a detailed health history including information about birth, illnesses, hospitalization, all treatments, immunization status, and current health concerns.

The day care program should also have a history form but it need cover only major health problems the child has had, with an emphasis on current developmental health concerns. This helps explain a child's current behavior and past experience.

Parents often know more than they think they know about their own child. Without someone making time for it, few parents review their child's nutritional, immunization, previous health or family history. Even for the most alert parent, the health needs of a child who is rapidly growing and changing may be innocently overlooked because of other urgent demands.

In many ways, taking a child's health history can reinforce the parents' role. You can assist parents in reviewing the child's health record for general health strengths and weaknesses. To look back and think about what the child's first two or three years were like helps explain the child's current status and reveals parent responses to health problems. Was the child ever taken to the emergency room? Were feedings difficult? Were there food allergies? Such experiences can be traumatic to the family as well as the child. Give parents the opportunity to tell you what they know.

A sample developmental health history form is presented in Figure 22. Use it as a guide to develop one that meets your needs. The sample form was adapted from an Office for Children form; others, including a more detailed one for infants and toddlers, are available from your OFC licensor.

Health Observations

■ OBSERVING PHYSICAL HEALTH

Health observations may be organized into *signs* and *symptoms*. Signs are specific observations (coughing, vomiting, or swelling). Symptoms are internal and must be described in order to be known to others (nausea, headache, or stomach ache). Signs and symptoms may occur together (vomiting from nausea or pulling on an ear from ear pain). Since young children often cannot express symptoms, our objective observations of signs usually provide the best clues.

Figure 22
Sample Developmental Health History–Short Form

Child's Name:____________________ **Birth Date:**__________
(Last) (First)
Nickname:____________________

PHYSICAL HEALTH

Does your child have any allergies (such as hay fever, foods, medicine)?______

Does your child take any medicine regularly? If so, what? __________

Has your child ever been hospitalized? If so, why and when?__________
____

Does your child have any recurring chronic illness or health problem (such as asthma or frequent earaches)?__________
____

Does your child have a disability which has been diagnosed (such as cerebral palsy, seizure disorder, developmental delay)?__________

Do you have any other concerns about your child's health?__________
____

DEVELOPMENT (compared to other children this age):

Does your child have any problems with talking? Please explain.__________
____

Does your child have any problems with walking, running, or moving around? Please explain.__________
____

Does your child have any problems seeing? Please explain.__________
____

Does your child have any problems hearing? Please explain.__________
____

Does your child have any problems using his/her hands (such as with puzzles, drawing, small building pieces)? Please explain.__________
____

DAILY LIVING

What is your child's typical eating pattern?__________

Does your child have strong food likes?__________Dislikes?__________

Does your child use table utensils (cup, fork, spoon)?__________
____

Figure 22 (cont.)

How does your child indicate bathroom needs? Word for urination:____________
Word for bowel movement:____________Special words for body parts:____________
____

What are your child's regular bowel and bladder patterns? Do you want us to follow a particular plan for toileting?____________________________________
____

For toddlers, please describe use of diapers or toileting equipment (such as potty, toilet seat adapter, etc.):____________________________________
____

What are your child's regular sleeping patterns?
Awakes at ____________ Naps at____________ Goes to bed at____________

What help does your child need dressing?____________________________
____

SOCIAL RELATIONSHIPS/PLAY

Has your child played with other children?____________________________

What ages are his/her most frequent playmates?________________________

By nature is s/he friendly?____aggressive?_____shy?_______withdrawn?___________

How does your child relate to strangers?______________________________
Does your child play well alone?______

What is your child's favorite toy?_______Is your child frightened by:
animals_________ rough children___ loud noises____ dark____ storms____
anything else_______

What is your child's favorite television show?________________________
How many hours a week does your child watch television?_______________

Who does most of the disciplining?__________ What is the best way of handling him/her?____

With what adults does your child have frequent contact?_______________

How do you comfort your child?_______________________________________

Does your child use a special comforting item (such as blanket, stuffed animal, doll)?____

______________________________ ______________________________
Parent's Signature Date

In order to be truly helpful, observations must be stated precisely. Rather than saying, "Jeffrey looks sick," it is more useful to say, "Jeffrey has a frequent dry cough, flushed cheeks, and a runny nose with thick yellow mucus." Report your specific observations rather than drawing conclusions or making a diagnosis. For instance, say, "Jennifer has a sore throat and fever of 102°" rather than saying, "Jennifer has a strep throat." State measurable facts whenever possible, such as, "Sarah has an oral temperature of 101.6°" rather than, "Sarah seems hot when I touch her forehead."

Health observations should include information gathered from every sense -- smell, hearing, seeing, touching. It is important to observe clues such as the texture of skin, breath odor, the appearance of a bruise, the sound of a cough.

Sometimes it is difficult to judge what is a significant finding. Observe the group in general and compare individual children. For example, do most of the children need help zipping their coats? If so, the fact that Susan asks for help is not a concern. If a child differs significantly from others in the group, it is worth noting.

Each observer has a different perspective in obtaining health information. Parents compare a child to his or her "typical" appearance or behavior or to siblings or friends. Teachers may have a similar view but also observe children in a group setting with many children of the same age. The physician or health provider uses the knowledge and experience from medical practice. Each view is valuable but limited; in order to have a total picture of the child, all observations from the "health team" must be shared and seen as a whole.

■ OBSERVING DEVELOPMENT

Physical health is only one part of a child's life. Equally important is early childhood development in the areas of language, gross and fine motor skills, social-emotional competence, and cognition (thinking). Problems in these areas often can be identified and worked out during the preschool years, and day care personnel are ideally situated to observe these problems. This task requires a particular set of skills:

1. *Knowledge of general child development (developmental milestones), with in-depth information about the particular age of children in your group.*

Over the past twenty years, the child development community has been moving away from a single set of "normal" developmental milestones to a more flexible view of how young children develop. For example, it used to be that many preschool programs for children over 2-1/2 years old would not accept children unless they were toilet-trained, because early childhood professionals were taught that children *should* be trained by that age. We now know that the "normal" range for toilet training extends past that age.

This more flexible view sees the influence of factors on child development such as family childrearing styles, cultural and ethnic norms, and a child's own temperament. For example, some children learn to feed themselves "late" because, in their particular culture, parents and grandparents get great pleasure from feeding their young children, even after children could actually feed themselves. Or, one child's ability to concentrate and "stick with" a task might spur her towards writing her name at three years old, while another child's more "laid-back" approach to writing tasks might not get him writing until 4-1/2 years of age. All these children probably are developing "normally."

While it is very important to know about developmental milestones, people who care for children must try to understand each individual child and the family and community from which s/he comes.

Developmental milestones are extremely helpful in providing a general framework for thinking about the children in your group and for identifying children whose abilities fall outside the normal ranges. The Preschool Enrichment Team, a program funded in part by the Department of Public Health, has developed a useful guide called "Developmental Red Flags" for observing children three to five years old in group preschool settings. (See Appendix 8.) These "red flags" are signs of potential trouble in areas of development, and the guide presents them in a clear, simple manner. Several points should be made before using "Developmental Red Flags":

- Look for patterns or clusters in the red flags you note. Isolated behaviors may not be significant.

- Observe the child in a variety of situations -- at different times of the day, in different groups and alone, and involved in different activities.

- Observe a child over a reasonable period of time. Do not jump to conclusions, especially during the adjustment period after enrollment.

- Compare the child's behavior with that of others in the group who are six months younger to six months older to give you a range of expected behaviors. A red flag at one age may be perfectly appropriate behavior at another.

- Remember, a child's behavior must be considered in the context of personality, culture, past experiences, family relationships, and the child's "match" with the style of the center.

- *Use the guide as a screening aid, not a developmental test or standard assessment tool. It is neither of those.*

There are a number of other screening and assessment tools which are used by developmental specialists and classroom teachers. The *Denver Developmental Screening Test* (DDST) is a standardized screening tool that is frequently used by health providers. It provides a useful framework for reviewing the range of normal childhood behaviors and developmental skills for children ages 2 weeks to 6 years; it tends to underrefer children with mild handicaps or risk factors. The *Early Screening Instrument* (ESI) is appropriate for children ages 4 to 6 years. It is brief and easily learned; it covers the same areas of development as the DDST. The *McCarthy Screening Test* (MST) includes 6 of the 18 subtests of the well-known McCarthy Scale of Children's Abilities and is appropriate for children ages 4 years to 6 1/2 years. The *Minneapolis Preschool Screening Instrument* (MPSI) covers the age range of 3 years, 7 months to 5 years, 4 months; it includes a larger number of classroom readiness tasks than the other tests mentioned.

More information on these four screening instruments and where to order them is provided in Appendix 9. In addition to ordering these directly from the publisher, you may be able to find them at college early childhood education programs, pediatric clinics, or through the Early Childhood Specialist at the nearest Department of Education Regional Education Center. (See Appendix 10 for a listing of these offices and phone numbers.)

Early Intervention programs funded by the Department of Public Health are located throughout the state and serve children ages birth to three years of age. (See page 207, Chapter 13, and Appendix 3.) They are staffed by experts in infant and toddler development who can be consulted about developmental concerns for this age group.

2. *Training in observing and recording children's behaviors and interpreting the information collected.*

At various times, every child care provider has concerns about an individual child. Perhaps the child's speech is more difficult to understand than others in the group. Or the child never participates in activities, is extremely afraid of others, and rarely smiles. These observations need to be documented -- written down -- so that patterns in the child's behavior can be identified and discussed with other staff members, and sometimes parents and outside consultants. Does the child's behavior depend on what group of children or adult(s) s/he is with? Is s/he different at different times of the day, or days of the week?

It is very important to write down behaviors or moods that seem to suggest problems in development. One technique is to keep file cards in your pocket and simply note the day, time, activity and behavior for a child you are observing. You might ask another staff member to pay special attention to a particular child over the course of a day or week and ask that staff member to record behaviors and events as well. That way you have more information to interpret and a better chance of taking the appropriate steps.

In order to understand the information you have collected, you need additional information on the child's "context" -- his environment. Is there anything going on at home which might affect his progress in the area of concern? Is it possible that the child has a medical condition which is affecting his/her behavior? Is there a new baby? Is there adequate space at home to crawl around and "exercise?" A lot of detective work goes into documenting the problem and determining what the next steps should be. In most cases, you should discuss your concerns with the child's parents at this point.

3. *Ability to communicate concerns about unusual or delayed development to parents in a supportive, nonthreatening manner.*

Parents are experts on their children and should be involved in discussions about developmental concerns early in the "screening" process. Their input can help you identify which behaviors are normal for the child and which occur only at the center, which are appropriate for his family and culture and which are not, and which behaviors or traits are of particular concern to the parents.

Often parents have concerns similar to yours, but may not have wanted to "bother" the staff with questions or appear to be overly concerned. Dealing with these concerns in a respectful partnership with day care staff can be a great help and support.

4. *Familiarity with community resources for referral and consultation.*

Most communities or regions in Massachusetts have a wide array of experts on every aspect of child development. Once a problem has been identified and confirmed by parents and other staff members, you should be familiar enough with your community to be able to make an appropriate referral to a competent and sympathetic diagnostician. Chapter 13 gives some general suggestions about state agencies and services. A list of local services should be kept at the center so that referrals can be made easily. Please refer to Appendices 7 and 8 for suggestions of other professionals or agencies who may be appropriate for referral.

Major Health Screenings

VALUE OF SCREENING FOR THE APPARENTLY WELL CHILD

The American Academy of Pediatrics recommends a minimum number of screening tests for sound health care; Head Start requires its programs to perform a similar set. These tests try to identify conditions which, if undetected and untreated, may seriously handicap a child for life. These conditions are important, occur quite often, and generally respond to early treatment. Early treatment is often more effective and less costly than later treatment and may also prevent the development of other problems.

For instance, a child with undetected hearing loss risks developing language, learning, and behavior problems. Children with eyes that are not straight and children with a marked difference in visual acuity between eyes are at risk for developing amblyopia (loss of vision in one eye due to lack of normal use). If decreased vision in one eye is not treated during the preschool years, treatment in the school-age years is slow and often unsuccessful. Another example is that a child who is undernourished may have poor attention skills or passive, low-energy behavior.

Screening is a practical means for early detection of disease or handicapping condition. A screening test separates those who possibly have impairment from those who probably do not. It identifies individuals who require more complete professional evaluation.

Screening generally involves short and simple procedures because it is intended for large numbers of apparently well children. A good screening may identify a few children who turn out not to have a problem, but it should miss very few who do have the problem. Without screening, problems may go unnoticed or, if signs or symptoms are recognized, their significance may not be understood.

Another reason for screening the apparently well child is that children are in a period of rapid growth and development. There are milestones which the child can be expected to reach within a certain range of time. Given the child's basic body structure, his/her growth should follow a predictable pattern. The child should be able to accomplish certain tasks by a certain age.

Screening is the first step in identifying children who are in need of special services. It is a relatively quick and economical method of looking at large numbers of apparently well children, some of whom may have handicapping conditions or correctable problems.

PRESCHOOL VISION SCREENING

The preschool years are important in the overall growth and development of children. It is during these years that lifelong habits and skills are developing. And it is during these years that developmental problems may be most effectively corrected. This is especially true in the areas of vision acuity and vision skills. *Vision acuity* means *sharpness* of vision -- the ability of each eye to distinguish detail both near and far. *Vision skills* refer to the *ability to use both eyes efficiently and effectively as a coordinated team.*

It is wise for all three- and four-year-old children to have a full eye examination by a vision specialist. This exam will often include evaluation of general eye health, near and far visual acuity, and several types of vision skills. At a minimum, however, every child should participate in a basic vision screening program.

Many people believe that preschool-age children "are too young to be tested." In fact, most three- and four-year-old children *can* cooperate with a vision screening program. And, effective and efficient visual acuity screening *can* be done by day care providers.

- Informal screening should be done by observing the child at play. Certain persistent symptoms may indicate the need for a thorough eye exam:

  - any tendency for an eye to wander or cross
  - frowning, scowling, squinting, blinking, or rubbing eyes
  - tilting head or working excessively close to materials
  - general developmental immaturity
  - poor large or small muscle coordination

- Formal screening is done with an age-appropriate, standardized screening tool designed to identify some of the most common problems found in preschoolers. Other problems may only be found through further testing. A valuable screening program must include:

  - parent education about vision and vision screening
  - parent involvement and consent
  - use of a valid, reliable tool appropriate for the age

- practice by the screener in advance
- screening and rescreening all children who fail before making referrals
- written information provided to the parents when further examination is suggested
- parental choice of an eye care specialist
- information received from the eye care specialist about examination results

The Snellen E (Tumbling E) and the Broken Wheel Test are recommended screening tools for three- to five-year-old children. Various picture identification tests are generally considered less accurate. See Appendix 24 for resource information. If you are interested in doing vision screening, it is important that you receive training; talk first with your health consultant.

A vision screening program for preschool children is valuable only if follow-up occurs. Children who fail should be seen by an eye care specialist for a complete eye evaluation. Treatment varies with the need of the child and with the type of eye care specialist. One should choose a specialist who has training and experience with young children and who seems to enjoy working with this age. *Do not assume that children will outgrow vision problems.* Some problems get worse. Early detection permits early treatment which will correct the problem more completely and which is less expensive than later treatment.

■ PRESCHOOL HEARING SCREENING

It is during the first few years of life, when a child's learning and understanding are being formed, that certain hearing problems are very common. Undetected and untreated, some of these problems can lead to more serious difficulties. A child who does not hear clearly will have trouble imitating sounds and developing language. Behavior can also be affected. Learning to read and to write will be difficult. Finally, permanent hearing loss may occur.

Hearing problems may be hereditary or the result of certain illnesses during pregnancy or early childhood. Temporary or intermittent hearing loss may be caused by chronic ear infection, a heavy buildup of wax in the ear, or chronic fluid in the middle ear.

Hearing loss may be readily observed when the loss is severe enough. There are signs which can alert parents and day care staff to milder loss also. An infant who does not hear well will not startle at a sudden noise, will not search with his or her eyes for the source of a noise, will not respond to a musical toy or a parent's voice unless the parent is seen, will be slow to imitate sounds and respond to simple commands or the sound of his or her name. Older children may have smaller vocabularies, use shorter sentences and seem to understand less than other children the same age. These signs may indicate intermittent hearing loss as a result of an ear infection or middle ear fluid. We may think the child has a learning or behavior problem when, in fact, it is a matter of hearing loss.

Hearing is perhaps the single most important sense for learning, yet it is possible to be totally unaware of a hearing problem unless the child is professionally examined and tested, or at the very least, screened.

There are three screening tests that, when combined with parent and teacher observation, are very effective and can be be used with preschoolers without difficulty. Pure tone audiometry (the typical hearing test) can be done on three- and four-year-olds with ease; it can sometimes be used for two-year-olds as well. It requires putting a toy in a box or raising the hand upon hearing a sound through earphones.

Two of the tests (tympanometry and acoustic reflex) test for fluid in the ear and can be done on even the very youngest child since they require no response. The value of tympanometry and acoustic reflex screening are currently under reassessment. These tests may be most appropriate for selected, high-risk children. Your health care consultant and other community specialists can assist in deciding who and how often to screen.

It is not recommended that you do hearing screenings yourself, but that you or parents arrange to have them done for the children in your center. Children are more comfortable and secure in familiar surroundings with familiar adults, so consider bringing the screeners to the children. Prepare the children and follow through on referrals.

Pure Tone Screening

Checks the child's ability to hear quiet sounds at four different pitches or frequencies.

Tympanometry

Measures the pressure required to move the eardrum (in the middle ear) and the way the eardrum moves. Negative pressure occurs when there is not enough air in the middle ear (usually because there is fluid there). Fluid in the middle ear will usually prevent the eardrum from moving, and may affect the child's ability to hear or to distinguish sounds clearly.

Acoustic reflex

This is the contraction of a muscle in the middle ear in the presence of a loud sound. If the reflex is absent, it may indicate fluid in the middle ear or incomplete healing from a recent infection.

■ MEASUREMENT OF HEIGHT AND WEIGHT

Height and weight should be measured regularly and properly recorded in a way that permits comparison with normal growth patterns. These measurements are one of the best ways to detect abnormal physical growth which may indicate a serious physical problem. Head circumference (measurement around the head) should be measured also for children during the period of most rapid growth, birth to two years of age.

Growth measurements should be taken regularly. This will usually be done by the child's health care provider; you should receive this information with the child's annual physical examination report. In some cases, the center may want to carry out height and weight measurements for children. Talk to your health consultant first; this can be a fun experience for the children as well.

To be well understood, height and weight information for children of all ages, and head circumference measurements for children up to age two, should always be plotted on a chart which shows normal growth patterns. See Appendix 11 for copies of standard growth charts for both boys and girls. Unless growth is plotted on a graph, it cannot be meaningfully interpreted by health care providers. Growth patterns should follow the normal growth curves of children of the same age and sex and fall between the fifth and 95th percentile curves on the standard growth chart. It is also important to note if a child's growth pattern makes a major shift from one curve to another. For example, a child who has been at the 80th percentile and drops to the 50th percentile is of concern. A child who has been at the 50th percentile and stays there is not of concern. Any significant variation from the normal growth pattern should be investigated; tell parents of any concerns you have.

■ LEAD SCREENING

Lead screening is extremely important because we know that even very low elevations of lead can cause problems in learning and behavior. Lead screening is performed by a simple finger-prick blood test; it should be done yearly between the ages of nine months and six years. Children between nine months and three years who live in high-risk areas should be tested every six months.

For additional information about lead poisoning, see Chapter 15.

Medical Examinations

A medical examination is a comprehensive review by a physician or nurse practitioner of all the health information gathered from the health history, health observations, and screening tests. The examination includes an interview with the parent or guardian to get current health information and immunizations, a complete physical examination, and laboratory tests as necessary (e.g., blood or urine). A dentist or eye specialist may also be involved. Medical examinations should be done frequently during the first three years of life, and yearly after age three during the preschool years.

The Office for Children Group Day Care Regulations require that each child have a physical examination within one year of enrollment (or within one month after admission) and yearly while the child is enrolled.

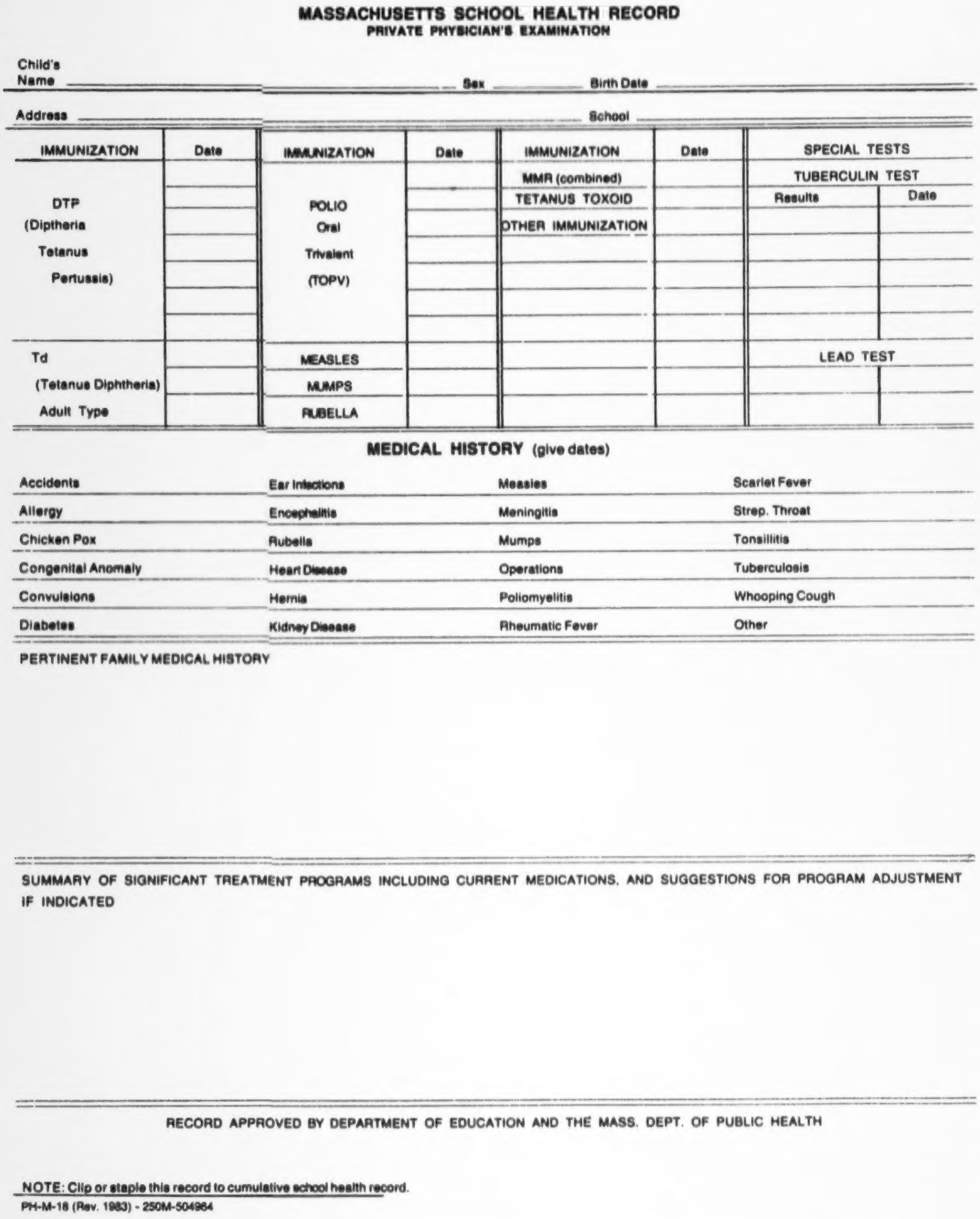
The results of the medical examination should be reported in detail on a child health form. The form, at a minimum, should include:

- any health condition that may affect the child's participation in day care
- history of significant illness and/or hospitalizations
- immunization status
- reports of any screening or assessment
- any significant observations of the parents' or siblings' health
- notations about physical, mental, and social development

A complete and detailed health form should give you an accurate picture of the child's unique development and health status. It should help you have realistic expectations and to plan appropriate activities. If the form is incomplete, the director, health consultant, or parent should contact the health provider for additional information. If any of the information is not understood, you should feel free to ask questions. Ask the health provider to give you practical, concrete information which directly relates to the day care experience.

The Massachusetts Private Physician's Examination Form (PH-M-18) is presented in Figure 23. This form is designed primarily for school-aged children, and copies are available free from the Massachusetts Department of Public Health; order forms are sent to all licensed day care centers annually along with the Department's immunization survey. At a future date, forms specifically designed for preschool-age children may also be available in bulk at no charge. In the meantime, this form, together with the developmental history form (Figure 22) can be used. You may want to add an extra page or specific questions to the form sent to the physician in order to get more detail on the child's early growth and development.

Figure 23
Sample Child Health Examination Form



MASSACHUSETTS SCHOOL HEALTH RECORD
PRIVATE PHYSICIAN'S EXAMINATION

Child's Name ______________________ Sex __________ Birth Date ______________

Address ______________________ School ______________

IMMUNIZATION	Date	IMMUNIZATION	Date	IMMUNIZATION	Date	SPECIAL TESTS	
DTP (Diptheria Tetanus Pertussis)		POLIO Oral Trivalent (TOPV)		MMR (combined)		TUBERCULIN TEST	
				TETANUS TOXOID		Results	Date
				OTHER IMMUNIZATION			
Td (Tetanus Diphtheria) Adult Type		MEASLES				LEAD TEST	
		MUMPS					
		RUBELLA					

MEDICAL HISTORY (give dates)

Accidents	Ear Infections	Measles	Scarlet Fever
Allergy	Encephalitis	Meningitis	Strep. Throat
Chicken Pox	Rubella	Mumps	Tonsilitis
Congenital Anomaly	Heart Disease	Operations	Tuberculosis
Convulsions	Hernia	Poliomyelitis	Whooping Cough
Diabetes	Kidney Disease	Rheumatic Fever	Other

PERTINENT FAMILY MEDICAL HISTORY

SUMMARY OF SIGNIFICANT TREATMENT PROGRAMS INCLUDING CURRENT MEDICATIONS, AND SUGGESTIONS FOR PROGRAM ADJUSTMENT IF INDICATED

RECORD APPROVED BY DEPARTMENT OF EDUCATION AND THE MASS. DEPT. OF PUBLIC HEALTH

NOTE: Clip or staple this record to cumulative school health record.
PH-M-18 (Rev. 1983) - 250M-504984

Figure 23 (cont.)

PRIVATE PHYSICIAN'S EXAMINATION

In order to ensure a quality standard of complete examination for each school child, please record your findings after each item

(O) normal (X) abnormal

DATE

Comment Treatment

Age .... BP ..../......... Pulse .... Hgt. .... Wgt. ....

Physical Development ....

Nutritional Status ....

Skin ....

Eyes .... sclera .... pupils ....

light & distance: r. .... l. ....

glasses ....

Ears .... canals: r. .... l. ....

drums: r. .... l. ....

Nose .... septum .... turbinates ....

Mouth .... lips .... tongue .... pharynx ....

Teeth .... gingiva ....

Neck .... mobility .... lymph nodes .... thyroid ....

Throat .... shape .... symmetry ....

Lungs ....

Heart .... rate .... rhythm .... murmur ....

Abdomen .... liver .... spleen ....

hernias ....

Ano-Genital .... anus .... penis .... labia ....

testicles: r. .... l. ....

Tanner stage: ....

Spine ....

Lower Extremities .... range of motion ....

development .... strength ....

Upper Extremities .... range of motion ....

development .... strength ....

Cranial Nerve .... I-XII ....

Gait ....

Coordination ....

Lab Tests

Hgb/Hct

Other:

Address ______________________ Date

______________________ M.D.
Signature

References

Dittman, Laura. Children in Day Care, With Focus on Health. Children's Bureau Publication No. 444-1967. Washington, DC: Superintendent of Documents, 1967 (Reprinted 1971).

Haggerty, R.J. Section II -- Health Promotion. In: Green, M. and Haggerty, R.J. (Eds.). Ambulatory Pediatrics III. New York: W.B. Saunders Company, 1984; pp. 27-37.

Meisels, S.J. Developmental Screening in Early Childhood: A guide. Revised Edition. Washington, D.C.: National Association for the Education of Young Children, 1985.

Nelson, H.M. and Aronson, S.S. Health Power: A blueprint for improving the health of children. New York: Westinghouse Health Systems, 1982.

North, A.F., Jr. Day Care 6: Health Services. A guide for project directors and health personnel.

Preschool Enrichment Team. Preschool Vision Screening: A reason to start young. Holyoke, MA: Preschool Enrichment Team, Inc., June, 1983.

Reinisch, E.H. and Minear, R.E., Jr. Health of the Preschool Child. New York: John Wiley & Sons, 1978.

10 Adult Health in Day Care

Introduction

Staff are the key ingredient to quality day care.

Day care staff, in fact, are very concerned about potential health hazards of working in day care. In a 1979 study of San Francisco child care workers, 67 percent stated that their health was negatively affected by their jobs. Some hazards cited were increased risk of getting illnesses; toxic substances in art supplies, cleaning agents, pesticides, etc; back problems due to frequent heavy lifting and furniture and environment designed for small children; poor lighting, high noise levels, clutter; and stress.

Very often, however, staff will ignore their own health needs concerned as they are that children's needs be considered first. While it is your job to respond to children's needs, what child will benefit from a burned-out or ill caregiver? *Placing value on your own health and safety will help both you and the children by preserving your physical and mental health.*

This chapter will address the following topics:

- Promoting Good Adult Health
- Health Examinations
- Infectious Disease in Day Care Employees
- When *Not* to Come to Work
- Substitutes and Breaks

Promoting Good Adult Health

Unfortunately, many day care providers neglect personal needs as adults because you focus on children's needs. Only when you care for yourselves, by keeping truly well and healthy, can you best care for children.

It is important to take the time to look at your day care environment and program demands. How can you make yourselves more comfortable? What policies need to be revised to meet adult needs? Are you encouraging good health? Can sick adults stay home without guilt?

With staff and administration working together, it need not be terribly difficult to adjust a center to the needs of the adults who work there as well as the children in their care. Some examples of simple solutions include:

- A high counter with stools (or just an adult-size table and chair) can be provided for clerical, administrative and curriculum work; adult-size folding chairs can be brought in for staff meetings; a phone book placed on a child-size chair can make it a much more comfortable seat.
- Private adult space and adequate back-up to allow for genuine breaks can decrease stress.
- Staff training in proper techniques for lifting and bending can prevent leg and back strain. (See Appendix 12, How to Care for Your Back, for some guidelines on lifting and bending.)
- Preventive health policies can reduce exposure to childhood illnesses.
- Providing gloves for use when working with cleaning agents can help prevent skin irritation.
- Practicing good preventive health procedures can help keep adults and children healthy.
- Break and substitute plans can be included in personnel policies.

The barriers to these and other solutions often are attitudinal rather than practical. Although most staff and directors can readily focus on child health and safety procedures and precautions, many have difficulty considering their own needs. Just because a center is baby- or child-proof (and most are), there is no guarantee that it is also adult-proof. Yet how safe can an environment be for children if the adults' needs are not met? Caring for children means caring for yourselves.

Health Examinations

Requiring health exams for ALL adults (staff AND volunteers) who work in the day care setting is the foundation for an adult health plan. The results of this exam are strictly confidential and can be given to the employer only with the staff member's permission. Each program should have a requirement for adult health examinations which specifies:

- content of the exam
- who can perform the exam
- how often it must occur
- special examinations for special roles, if any
- who receives the findings
- where the examinations can be performed and
- who pays for the exam.

In order to be effective, the health professional must know the nature and demands of the child care role. For instance, a chronic lower back problem may not interfere with the job performance of a social worker but surely would affect the teacher of a toddler group.

■ PRE-EMPLOYMENT EXAMS

Ideally, the results of the health exam should be received *before the job offer is final and before contact with the children begins.* In practice, this is difficult to do - but it is still very important. It is hard to deal with health concerns after the individual has begun to develop relationships in your setting. An assessment may reveal risks to which other staff and the children have already been exposed.

The issues for the pre-employment exams are:

- physical and emotional fitness for the job

- immunization status and history of childhood infectious diseases such as chickenpox and rubella

- disease which might result in frequent absence from the job

- conditions which might require emergency care

- limitations in situations common in day care such as difficulty being outdoors, skin conditions affected by frequent hand washing, allergy to art materials, etc.

- medication or special diet requirements which might affect job performance

- good vision and hearing

- special tests for bus drivers including: visual field, color and depth perception, EKG.

OFC Group Day Care Regulations require specifically "written certification from a physician that a staff member is free from communicable disease and indicating any limitations the staff member may have in working with young children due to health problems." [102 CMR: 707(19)] There is no specific form for this purpose.

Some poorly controlled health conditions might disqualify a person from being hired because they may affect the safety of the children: a poorly controlled seizure disorder or obvious lack of stamina, for example. If these conditions are identified after a person has been hired, you may wish to make adjustments to allow the person to continue; examples of such adjustments are a change to part-time work, a change in role, or a temporary leave of absence.

■ OTHER EXAMS

Health exams may also be needed at other times. These include:

- Before probationary period is complete if health concerns have been raised.

- After a severe or prolonged illness so as to help identify continued disabilities, necessary modifications, and expected transition time to resume a full work role.

- On return from a job-related injury, when a written release protects the program from liability for allowing the adult back on the job.

- Whenever a health condition seems to be affecting job performance, no matter when the last assessment was done.

- When a promotion or reassignment to another role could be affected by the adult's health status.

- Whenever there are legal liability issues such as adults with a history of back injuries, more than one heart attack, mental illness, stress-related conditions, etc.

- After certain infectious diseases, to ensure the adult is no longer contagious.

Infectious Diseases in Day Care Employees

Infectious diseases are common in day care centers. Most are not serious and would probably spread at a similar rate from children to adults in a large family setting.

Because day care staff are caring for a number of young children, many of whom cannot control their secretions and have not yet learned principles of hygiene, there is the potential for spread of infections to the employee. Employees may pass infection to other employees, children, family members, and in the case of a pregnant employee, there may be transmission to the fetus. Therefore, it is important that the employee be familiar with the infections that are common in the day care setting, and the measures s/he can take to prevent them. Specific details on these infections and ways to reduce their spread are contained in Chapter 17.

There are two important barriers against the spread of infection: immunization and hygiene; that is, by being immunized against certain diseases and by using proper food handling and handwashing techniques.

Safe, effective vaccines exist against many serious diseases including measles, mumps, rubella, diphtheria, tetanus, and polio. These vaccines are strongly recommended for day care center employees. (For further detail, see section on Vaccine-Preventable Diseases in Chapter 17.) Additionally, vaccine against the influenza virus (given yearly) may be advisable.

The most effective measure to prevent spread of most infectious diseases. is careful handwashing after contact with potentially infectious secretions, along with proper handling of contaminated items. Body secretions include saliva, tears, nasal discharge, urine, stool, phlegm, mucus, vomitus, blood, pus, ooze, etc. *ALL blood and secretions from ALL children should be handled as potentially infectious.* (See Figure 6, and General Principles sections in Chapter 17 for details). *Use disposable latex gloves as necessary. (See page 33.)*

Women of childbearing age should be aware that several infectious diseases that can occur in children in the day care setting can infect a developing baby and can cause miscarriage, birth defects, or illness in the newborn. These infections include rubella, measles, mumps, Hepatitis B, cytomegalovirus, Herpes, and AIDS. The first four diseases are preventable by immunization. They and the other diseases are discussed in detail in Chapter 17. Routine immunization (or other proof of immunity) is strongly recommended for the first three diseases: measles, mumps, and rubella. In certain settings, an increased risk of Hepatitis B infection could exist. In those cases, vaccination is recommended for persons who have daily close contact with children who have or are at high risk of having Hepatitis B. Strict attention to handwashing and care with ALL children's blood and body secretions are the most effective safeguards for susceptible women against those infections for which there are no vaccines.

When Not to Come to Work

Most people recognize that minor illness is part of the day care setting. It is expected that children will catch colds and flu. Adults working daily with young children are also likely to become ill. Yet, because of the difficulty of arranging for and keeping dependable substitutes, many centers function without adequate substitute policies. The result is that many staff keep working when they are ill, convincing themselves that they really are not "that sick." Upgrading substitute coverage is critical to a well-run day care center but creating a reliable substitute policy is a difficult task. As with ill children, each situation with an adult is unique. In general, the best guideline to use is:

Adults should not come into the center if they cannot comfortably and capably perform their daily activities. Adequate personnel policies should be written to allow for and, in fact, to encourage adults to stay at home when they feel too sick to work.

Staff often come to work sick because of fear of lost pay or feelings of guilt due to inadequate substitute coverage. All staff must make a choice which balances their personal concerns and those of the program. *There are no absolute right or wrong decisions except in the rare cases of exposing other staff and children to serious contagious diseases.*

Adults with serious illness such as meningitis or chickenpox should not be at the center. Adults with other contagious diseases (e.g., strep throat, lice, impetigo) may return after treatment is begun (see Chapter 17). An adult with mild diarrhea or herpetic cold sores may work but must take extreme precautions in personal hygiene.

Substitutes and Breaks

The Child Care Employee Project has offered these suggestions to assist you in developing adequate substitute and break policies.

SUBSTITUTES

- Let parents know about the center's substitute procedure. They will appreciate your care and attention to staff illness.

- Consider joining with other centers to hire a sub who rotates between programs. This allows each center some guaranteed coverage and provides dependable employment for the sub. If nobody is absent on your scheduled day, the sub can supervise while regular staff attend to parent conferences, planning, etc.

- Set a decent salary for substitutes.

- Regularly evaluate your center's substitute policy. Keep the sub list active; call subs periodically to make sure they are still available.

BREAKS

Because of the cost of hiring additional staff, most centers must work with existing personnel during staff breaks. Following are some suggestions for coping with limited staff.

- Utilize administrative and support staff to cover breaks. Some centers assign nonteaching staff to cover breaks on different days of the week.

- Integrate volunteers to cover breaks. Assign parents, students, or community members as floaters. The key to making this plan work is regular scheduling and dependable volunteers! There should also be a thorough orientation given to each volunteer concerning the duties and responsibilities of a floater.

- If budget and staff/child ratio requirements allow, designate one staff member as a floater during break time for a week at a time. This person then becomes familiar with each of the classrooms in a large center and also gains perspective on the program by changing roles.

- Overlap staff shifts. Some centers arrange for afternoon shifts to begin during the last half hour of the morning shift. Though more expensive, this model facilitates covering breaks and also allows teachers time to share concerns and communication regarding their program.

- Provide an inviting space for staff that encourages relaxation during breaks. Too often the staff lounge -- if it exists at all -- doubles as an office, storage room and/or place for a sick child. Even if space is limited, a comfortable chair placed in front of a window can serve as a place to relax. If at all possible, the center budget should pay for coffee, tea, juice, or other refreshments for the staff to enjoy.

References

Child Care Employee Project. Health and Safety Resources for Child Care Workers. Various materials available from the Project, P.O. Box 5603, Berkeley, CA 94705.

Aronson, S.S. Why is adult health an issue in day care? Child Care Information Exchange, March, 1984, pp. 26-28.

11 Dental Health

Introduction

Diseases of the mouth are one of the most common health problems, affecting about 98 percent of the entire population at some point in their lives. By the age of three, most children have decay in more than one tooth. Head Start surveys in 1974 showed that between 60 and 70 percent of all three- and four-year-old children had caries (decay). Currently about 14 percent of six- to eleven-year-olds have periodontal (gum) disease, the other most common mouth disease.

The type of hygiene and dental care a child receives, along with diet and heredity, will determine the child's dental health throughout life. Day care programs can help prevent dental disease by serving well-balanced nutritious food and by limiting sugared and sticky foods. You can also promote dental health by providing fluoride tablets or drops (with parental permission), teaching children and staff about good dental care, having children brush their teeth at the center, and observing for dental problems.

This chapter includes the following topics:

- Healthy Foods for Teeth
- Fluoride
- Brushing Teeth at the Center
- Dental Health Education
- Visits to the Dentist
- Special Dental Problems

Healthy Foods for Teeth

High sugar foods are clearly linked to tooth decay. Avoid or limit sweetened drinks, candy, jelly, jam, and sweetened desserts such as cake, cookies, jello, and sweetened canned fruit. Fresh fruit makes a great snack or dessert.

Here are some important facts about sugar and teeth:

1. Natural sugars such as maple syrup and honey are just as harmful to teeth as refined sugar.

2. Sticky sweets (such as caramel) are particularly harmful because they remain on the teeth longer than other sweets.

3. Eating a sweet all at once is better than eating one for a long time (such as a lollipop), or often (such as popping mints or hard candies every 20 minutes).

4. Frequent snacking is not a good idea because the teeth are attacked by the decay process throughout the day.

5. Even sweet fruits, such as raisins and dates, should be eaten with a meal because they are sticky and very high in natural sugar.

6. Never put a baby to bed with a bottle of milk, formula, sweetened liquids, or fruit juices. The sugars in all of these liquids stay on the teeth for a long time and cause serious decay called "nursing bottle mouth" (see page 160).

7. Never reward good behavior with candy or other sweets.

Please refer to Chapter 12, Nutrition, for more information.

Fluoride

Fluoridation of public water supplies is the single most effective method of preventing tooth decay. When children have fluoride in their drinking water or supplements from birth, tooth decay is reduced 50-70 percent! Please refer to Appendix 13 for a list of Massachusetts communities which fluoridate their water. In communities that are not fluoridated, or do not have a community water supply, fluoride supplements are the most suitable way to reduce tooth decay in preschool children. Where water is not fluoridated, day care centers could provide fluoride drops or tablets to children at the center with parents' permission. After two years, 25 to 35 percent of the decay could be reduced.

The Division of Dental Health of the Massachusetts Department of Public Health has a preschool fluoride program. Their staff will provide your staff with training and all the necessary supplies, including the fluoride tablets. There is no cost for this service.

Any licensed day-care center is eligible for the fluoridation program if it meets the selection criteria, successfully completes the application and registration process, and has the ability to promote and monitor the program. Selection criteria include:

1. The center is in a non-fluoridated community.
2. The children are not receiving other systemic fluoride supplements (tablets or drops).
3. The center has at least one class with a minimum of fifteen children meeting five days a week.

☎ *For more information, call 617-727-0732.*

Brushing Teeth at the Center

Very young children can learn good habits that will last into adulthood. Brushing teeth after lunch and/or snacks at the center has the double benefit of cleaning teeth *and* teaching a good habit. This routine, if it is organized well, will probably not take more than five minutes a day. Some points to remember are:

- Each child must have his/her own toothbrush, labeled by name, which must never be shared.
- Toothbrushes must be stored properly so that they stay clean and open to the air. The bristles should not touch any surface. One method is to use a styrofoam egg carton. Clean it with alcohol, turn it upside down, and punch a hole in the bottom of each egg compartment. Store the brushes bristle side up so they do not touch each other.
- Most dentists and hygienists recommend a small toothbrush with:
    - Soft, rounded, nylon bristles
    - A straight handle
    - An even brushing surface
    - A head small enough to reach every tooth.

  When the bristles become bent, the brush doesn't clean well and should be replaced. Brushes should be replaced every three to four months or as necessary.
- Only use toothpaste with flouride. Use only a small amount (the size of a pea) and encourage children to spit it out. Use toothpaste only for children who will not swallow it; swallowed

toothpaste can cause irregular doses of fluoride. To discourage children from eating it, do not use a highly flavored toothpaste.

- An adult should supervise toothbrushing.
- Teach children proper brushing technique; get help from a dentist or hygienist if needed. It has been shown that the circular motion is easy and effective. Guidelines for proper brushing are:
  - Direct the bristles at a 45-degree angle where the teeth and gums meet.
  - Brush the outside and inside surfaces of the teeth. Place the bristles of the toothbrush where the teeth and gums come together. Move the brush in short, circular motion, back and forth, brushing the gums as well as the teeth.
  - Brush the top (chewing) surfaces. Scrub back and forth.
  - Use a systematic routine every time. Begin with the top teeth, outside surface in the back right side. Follow the arch around to the left side. Follow the same system for the inside surfaces. Brush chewing surfaces on both sides. Brush the bottom teeth using the same routine.
  - Brush the tongue.

Dental Health Education

Children and parents must understand the importance of good dental health. Children can be taught effectively through an integration of dental education activities with their regular activities.

Special parent programs can be planned and publicized through articles in your newsletter, parent handouts, posters, films, etc. Often brochures are available to describe particular problems, conditions, or resources. See Appendix 24 for further information on resources. The Division of Dental Health of the Massachusetts Department of Public Health has resource guides available with suggestions on where to obtain dental care educational materials and supplies.

Some dentists or hygienists are willing to come to the classroom for a special visit. A field trip to a dentist's office can be a wonderful introduction to regular dental care.

Visits to the Dentist

Encourage parents to follow healthy dental routines and to get regular dental care. A day care program can help parents find good dental care. It would be helpful to have a list of dental care resources available for parents who do not already have a dentist. It is best to find a children's dentist (pedodontist) or a family dentist who works regularly with children. When necessary, the day care center staff may want to assist in arranging the appointments, transportation, and follow-up. Some area resources may include dental health clinics, dental school clinics, community health centers, and for emergencies, hospital emergency rooms.

The first visit to the dentist should be at about three years of age or when all twenty baby teeth are showing. Since children usually need little treatment at this stage, the dentist can form a friendly and relaxed relationship with the child. The dentist can also look for early signs of future problems such as overcrowding or poor dental hygiene (cleanliness).

Try to make dental visits an important adventure for the child. Tell the child that the dentist is a friendly doctor who will help keep his/her teeth and mouth healthy. Talk about the visit in a positive, matter-of-fact way as you would any new experience. It is important to prevent fear. Avoid statements that suggest the visit may be unpleasant, such as, "It won't hurt." If you are fearful about dental visits, try not to let the child know. A good first trip will help mold the child's feelings for many years.

You can help promote children's dental health by observing carefully. When any of the following problems occur, suggest that the parent take the child to the dentist as soon as possible.

- Redness, swelling, or bleeding of the gums
- Swelling of the face
- Complaints of pain by the child
- Very dark or discolored teeth or holes in teeth
- Complaints when the child eats hard, hot, cold, or sweet food
- Broken teeth
- Spaces from first teeth that fell out too early
- Constant bad breath

Figure 24 provides specific guidelines for referral to a dentist for three-year-old children.

Figure 24

Dental Referral Criteria for Three-Year-Old Children

For most children under three, a visit to a dentist is purely an educational experience. However, there are cases where consultation with a dentist is recommended. Listed below are things to observe in three-year-old children. If you answer "no" to any of the questions, you should recommend that the child's parents consult a dentist.

SOFT TISSUES (TONGUE, LIPS, CHEEK, GUMS)

- Can the child stick his tongue tip completely out of his mouth?
- Can she swallow with her teeth together -- without the tongue pushing through each time?
- Are the upper and lower lip the same size?
- Is there a clear distinction between lip and skin of face?
- Is the color inside the cheeks even throughout?
- Are gum tissues same color, top and bottom? Front to back? Are gums free of pimples and/or swelling?

HARD TISSUES (TEETH)

Number

- Are there 20 teeth, 10 in each jaw?
- Are there the same number of teeth on either side of the middle of the jaw?
- Are teeth on either side the same shape?

Bite

- When the child closes his or her mouth, do the top teeth bite over the bottom teeth? Do the back teeth meet?
- Do all the teeth come in contact when the jaw is closed?
- Are the teeth spaced out, not crowded?

Color

- Are the teeth milky white? Are they an even color from tips to gumline?
- Are the top, bottom, front, and back teeth all the same color?
- Do any stains and colors come off easily with a toothbrush?

ORAL HYGIENE

- Are the teeth clean?
- Does the mouth have a clean, sweet odor?

Special Dental Problems

BROKEN TOOTH

Contact the parent. The child should see the dentist immediately. If a broken tooth is not cared for, the tooth can be lost. An X-ray examination may be needed to find out what damage has been done. Sometimes all the dentist has to do is smooth the rough edges of the break. If the break is more serious, the tooth may need to be medicated and covered with a crown, a metal band, or plastic material to protect it from further injury.

KNOCKED OUT TOOTH

Contact the parent. SAVE THE TOOTH! Sometimes it can be replanted in the jaw. DO NOT clean the tooth. Simply put it in a wet cloth or in a glass of water or milk. Rush the child and the tooth to the dentist (within 30 to 90 minutes if possible). The sooner the child sees the dentist, the better the chance of saving the tooth.

TOOTHACHE

Ask the parent to call the dentist at once. The dentist will find the cause of the toothache and will reduce the pain as quickly as possible. If emergency care is needed, there are several things you may do. If a cavity can be seen in the tooth that aches, flush out any food particles with warm water. Oil of clove may be put directly into the aching tooth or aspirin or acetominophen (e.g., Tylenol) can be swallowed for temporary relief of pain. (Use any of these only with parental permission.) Do not place the aspirin directly onto the tooth.

Remember, these are only temporary, emergency measures to be used only when a child is in extreme pain. Arrange a dentist appointment immediately.

THUMBSUCKING

Thumbsucking during the first several years should cause no concern. It gives the baby a feeling of pleasure and security. However, if the child continues thumbsucking beyond the age of five, it can affect the position of the incoming permanent teeth and the shape of the jaws. The pressures of thumbsucking may push the teeth out and narrow the dental arches. Eventually orthodontic care may be needed.

■ NURSING BOTTLE MOUTH

Nursing bottle mouth is a condition that can destroy the teeth of an infant or young child. The teeth most likely to be damaged are the upper front teeth, but other teeth may also be affected. It is caused by the frequent and lengthy exposure of a child's teeth to liquids containing sugars. Among these liquids are milk, formula, fruit juice, and other sweetened liquids. Nursing bottle mouth is caused not only by the sugars themselves, but also by how often and for how long a time teeth are exposed to the sugars.

Allowing a child to have frequent bottles of these liquids as a pacifier is not a good idea. Allowing a child to fall asleep with a bottle during naps or at night can do serious harm to the child's teeth, since the liquids pool around the teeth for long periods of time. If a child falls asleep with a bottle, remove it and use a wet washcloth, paper towel or napkin to wipe the liquid from all tooth surfaces. This is very difficult to do but can be avoided by not letting children have sugar-containing bottles near naptime.

References

Care of Children's Teeth. American Dental Association, 1976.

Moss, S. J. Your Child's Teeth. New York: Brentano's, 1977.

Nursing Bottle Mouth. Pamphlet published by the American Dental Association, 1983.

12 Nutrition in Day Care

Introduction

Good nutrition is an essential ingredient of quality day care. Tasty, colorful, nutritious foods and a pleasant, relaxed eating environment contribute to a child's sense of well-being. A child develops lifelong eating habits as a result of early eating experiences. As a day care provider, you need to know the nutritional requirements of children and how to provide a nutritious diet. Equally important is the atmosphere you create at meal and snack time.

Eating situations provide an opportunity to learn, socialize, and share with others. The process of eating helps a child develop new skills and learn about his/her body. Young children use all their senses to eat. As a child learns about different cultural patterns and food practices, appreciation and respect for others is developed.

Here are some simple, practical guidelines for good nutrition when planning meals and snacks for children.

- Provide a variety of foods each day. One food cannot supply all the nutrients a child needs.
- Establish regular times for meals and snacks.
- Offer portions appropriate to a child's age; discourage overeating.
- As part of a well-balanced diet, offer snacks between meals. Children often need more food than they are able to eat at regular meal-time. Limit snacks that provide mainly calories and low levels of essential nutrients.
- Encourage eating habits which are consistent with good dental health.
- Avoid serving foods with excess sodium, cholesterol, fat, and sugar.

The following outline lists the topics covered in this chapter:

Feeding Infants

- Breast Milk Is Best
- Introducing Solid Food
  - Finger Foods
  - Table Foods
- Cow's Milk - When to Begin
- Nursing Bottle Syndrome

Feeding Toddlers

- How Much Is Enough?
- The Eating Environment

Nutritional Principles for All Preschool Children

- Food Groups and Major Nutrients
- Snacks
- Appetite
- Food Habits - Variety is Essential
- Food Habits are Learned
- Introducing New Foods
- Food As Reward or Punishment?
- Food Safety
- Activity and Physical Exercise
- Common Nutritional Concerns
  - Fats, Sugar, Salt, Vegetarian Diets, Milk

Special Nutritional Problems

- Obesity
- Anemia
- Failure to Thrive
- Food Allergies and Intolerances
- Lactose Intolerance
- Hyperactivity

Feeding Children With Handicapping Conditions

- General Information
- Special Nutritional Concerns
  - Obesity
  - Underweight
  - Behavioral problems
  - Inborn errors of metabolism
  - Other metabolic problems

Nutrition Education

- Dietary Guidelines
- Nutrition Education with Children
- Involving Parents

Food Service

- Menu Planning
- Guide for Food Preparation and Storage
  - Food Purchasing
  - Food Storage
  - Infant Forumulas and Foods
  - Food Preparation and Storage
  - Storage of Non-Food Supplies
  - Cleaning and Care of Equipment
  - Insect and Rodent Control

Community Nutrition Resources

- Child Care Food Program (CCFP)
- Food Distribution Program
- Food Stamp Program
- WIC
- Nutrition Education and Training Program (NETP)
- Emergency Feeding Agencies
- Additional Resources

Feeding Infants

During the first year of life, more changes in diet occur than at any other time in life. During this time, infants are growing rapidly and developing motor skills. They quickly progress from sucking liquids through a nipple to feeding themselves table foods. Although feeding skills are developed in a systematic order, each child progresses through this sequence at his/her own pace. (Refer to Developmental Sequence of Feeding Skills in Appendix 14.) Interaction with caregivers has a strong influence on the infant's development of self-feeding skills and acceptance of a variety of foods. See Appendix 15, Infant Feeding Guide, for additional information and guidance.

■ BREAST MILK IS BEST

Breast milk is the recommended food for infants as it is uniquely suited to support the growth of infants. Breastfed infants need vitamin D and fluoride supplements. If a woman chooses not to breastfeed, iron-fortified formula is the best choice. Until about four to six months of age, infants are not physically ready to eat and digest other kinds of food. If other foods such as baby cereals are given during the first four months, the infant will consume less breast milk or formula, which are more appropriate nutritionally. Infants given solid foods before four months of age are more likely to be overfed or develop allergies.

An increasing number of infants in day care centers are being breastfed. You can help promote breastfeeding and support nursing mothers by following some simple guidelines:

- Provide a quiet, private place with a comfortable chair or cushion for the mother to nurse before departure, on arrival, or during her work breaks.

- Establish a bottlefeeding schedule which ensures the baby is eager to nurse when the mother arrives (i.e., set the feeding time for at least 2-1/2 hours before her arrival).

- Follow the guidelines for safe storage and handling of expressed breastmilk. (See p. 191.)

- Be informed about the basics of breastfeeding and provide support for the mother. Remember, a mother does not "lose her milk" when she bottlefeeds part-time. A full supply of breastmilk can be maintained, especially if the mother breastfeeds fulltime while the baby is with her.

■ INTRODUCING SOLID FOODS

Experts recommend starting solid food when infants are between four to six months old. Until this time, the infant's digestive tract is not able to completely break down the food; consequently, allergic reactions or sensitivities to solid foods may be more likely. Also, the infant's neuromuscular skills needed for self-feeding and swallowing are not well developed. Therefore, it is best to begin semisolid foods (e.g., rice cereal) between four to six months. Between six to eight months, vegetables and fruits should be added to the diet. At about eight to nine months, offer food with lumps (including table food that the baby can easily chew or mash). By the end of the first year, the baby should be eating most table foods. (See Developmental Sequence of Feeding Skills in Appendix 14.)

It is wise to add only one new food at a time and to wait three to five days before adding another to see if there is an allergic reaction. The most important point is that the variety introduced now is setting the pattern for food habits throughout life.

When starting solids, let the baby self-feed using his/her hands or use a spoon, preferably small, to feed the infant. Never put solid food or cereal into the bottle. They increase the amount of calories in the formula and could force the baby to take too many calories. A little time may be necessary to allow the baby to get used to the feel and taste of solid foods.

Finger Foods

Finger foods are usually introduced between eight and ten months. Finger foods encourage self-feeding, are well-accepted and easy to handle. To prepare, cut meat and cheese into small pieces, vegetables into strips, and fruit into sections.

Table Foods

Table foods are introduced at around eight months. Meat and other protein sources besides milk are usually added to the diet at this time. (Until now, breast milk or formula has been the primary source of protein.) Since babies do not chew until 18-24 months of age, the meat or other protein food should be strained, chopped, or cut into small pieces to make chewing easier. Lean hamburger, chicken, and fish are good choices. Do not be concerned if a child does not eat red meat. Chicken, fish, cooked, mashed dry beans and peas are other sources of protein that can be offered at this time. Spread peanut butter on other foods to avoid potential choking. Usually wheat products are avoided until after seven months since wheat is a common cause of allergies. By ten months, babies are at less risk for egg allergy and are ready to eat a scrambled or soft-cooked egg. Limit eggs to three or four per week. The baby is also ready for a variety of juices. These should be *100 percent fruit juice.* Juice drinks contain only about 10 percent fruit juice with the remaining ingredients being water and sugar, and thus are not acceptable.

■ COW'S MILK - WHEN TO BEGIN

Formula or breast milk is more nutritious and digestible than cow's milk and is preferred for young infants. Cow's milk is usually introduced between six and twelve months if infants get 1/3 of their calories from a balanced diet (including cereal, fruits and vegetables) and don't have a medical condition that wouldn't allow it (such as anemia, allergies or digestive trouble). Whole milk is recommended since the infant needs the fat, cholesterol, and vitamin E contained in whole milk for brain and nerve development. *Low fat or skim milk should never be given until the infant is at least twelve months old, and is not recommended until 18 to 24 months.* Low fat and skim milk contain fewer calories than whole milk due to lower fat content. Consequently, infants given skim or low fat milk may not consume enough calories. In addition, lowfat and skim milk contain too few of the essential fatty acids and cholesterol and too much protein in proportion to calories.

■ NURSING BOTTLE MOUTH

Infants or toddlers should not be allowed to fall asleep with a bottle. Formula, milk, juice and sweetened drinks contain natural sugars which can decay existing or erupting teeth. This may lead to early loss of teeth. As a result, the child may not be able to chew food properly and crowding may occur in the adult teeth. This is known as "nursing bottle mouth." If a bottle must be taken to bed, it should contain only plain water. Juice should be limited until the infant can drink out of a cup to avoid nursing bottle mouth.

Feeding Toddlers

During the period from eighteen months to three years, a child's growth rate slows down. As a result, a toddler eats less. Toddlers are demanding and energetic by nature. As they explore and gain control over themselves and their environment, they feel successful and become more independent. They begin to take more responsibility for what and how much they eat. For example, toddlers may go on food jags where they eat only a few foods over and over again.

As a day care provider, you are responsible for *what* the children are offered to eat, as well as *where, when,* and *how* food is offered. The toddler is responsible for *how much* food s/he eats. Your role is to help the child establish positive attitudes about eating, as well as assure a nutritiously adequate diet. You can help toddlers become independent by encouraging them to select from a variety of acceptable foods. Observe how energetic a toddler is, how s/he plays, grows, and eats. Be reassured that most toddlers are well nourished.

■ HOW MUCH IS ENOUGH?

It is very important for day care providers to be aware of child-sized portions. As adults, we frequently judge how much a child should eat by the quantities we eat. When too much food is put on a child's plate, the child feels overwhelmed and may not even try to eat. A good rule to follow is to offer one-fourth to one-third of a usual adult-portion or one tablespoon per year of age, whichever seems more appropriate. Give less than you think a toddler will eat and let him/her ask for seconds. Use the Preschool Feeding Guide (Appendix 16) to estimate appropriate portion sizes for toddlers. These are minimum amounts for achieving a nutritionally adequate diet and are not intended to limit the amount the toddler is allowed to eat. There will be daily variation in both types of foods and calories consumed by the toddler. Children one to three years of age consume approximately 1000-1300 calories per day. On a weekly average, a toddler should be eating a nutritionally balanced diet.

■ THE EATING ENVIRONMENT

A pleasant, relaxed eating environment helps toddlers develop positive attitudes about food. Establish regular meal and snack times. Make sure the toddler sits at a comfortable height in relation to the table where feet can touch the floor. Use plates and utensils appropriate to the child's size. Offer silverware, but don't insist that the toddler use it. If you allow the toddler to touch, smell, and explore food, s/he is more likely to eat it. Developing positive attitudes about eating at this time is much more important than fine-tuned table manners. As a toddler gets older, there will be less mess and greater ease in handling utensils and eating a variety of foods.

Encourage toddlers to try new foods, but don't praise a child for eating too much because this interferes with the toddler's self-regulation. Start slowly. Serve small portions of new foods. Encourage the toddler to try one bite of a new food; don't expect the child to eat a whole serving. Prior to a meal, try to help the toddler relax and settle down. If children are tired or overstimulated from play, they may not feel like eating.

The same nutritional and behavioral principles of feeding apply as the child grows up. However, as children get older, they are more selective about what and when they eat. The remainder of the chapter will focus on general nutritional principles and concerns that apply to all preschool children.

Nutritional Principles for All Preschool Children

FOOD GROUPS AND MAJOR NUTRIENTS

Foods can be divided into groups according to the major nutrients they contain. These groupings are known as food groups. The following list identifies the major food groups and the daily minimum servings from each food group needed by preschoolers for proper growth and development. Teach children about nutrition by discussing the foods served at meals. The Infant and Preschool Feeding Guides (Appendices 15 and 16) provide more information on appropriate serving sizes for different foods in each food group.

Vegetables and Fruits -- four or more servings daily

Include one good vitamin C source each day:
Citrus fruits (oranges, grapefruits), cantaloupes, strawberries, raw cabbage, and broccoli are high in vitamin C.

Include one good vitamin A source at least every other day:
Dark green and deep yellow vegetables such as winter squash, carrots and sweet potatoes, and fruits such as apricots are high in vitamin A.

Unpeeled fruits and vegetables and those with edible seeds (such as berries) are good sources of fiber. Nearly all vegetables and fruits are low in fat and none contain cholesterol.

Breads and Cereals -- four or more servings daily

Select only whole grain, enriched or fortified products:
Include whole grain bread and cereals or products made with enriched flour or meal, e.g., cornmeal, grits, rolled oats, barley, bulghur, macaroni or spaghetti, cooked or ready-to-eat cereals, biscuits, muffins, and pancakes.

These whole grain or enriched foods contain B vitamins and iron. They also provide protein and are an important source of this nutrient in vegetarian diets. Whole grain products also contribute magnesium, folacin, and fiber.

Milk and Milk Products -- two to three servings daily

Includes milk in any form: whole, skim, lowfat, evaporated, buttermilk, and nonfat dry milk; also, yogurt, ice cream, ice milk, and cheese, including cottage cheese. Lowfat and skim milk dairy products are preferred for children over two years of age. Low fat or skim milk is not recommended for children before 18 to 24 months of age.

Milk used in cooked foods - such as creamed soups, sauces, and puddings - can count toward meeting the preschoolers' milk requirement. Milk and milk products provide calcium, riboflavin, protein, and vitamins A, B_6, and B_{12}. They also provide vitamin D when fortified with this vitamin. Milk and milk products are the major source of calcium in the American diet.

Fortified (with vitamins A and D) lowfat or skim milk products have essentially the same nutrients as whole milk products but have fewer calories due to reduced fat content.

Meat and Meat Alternatives -- two or more servings daily

Includes lean meats, poultry, fish, dry beans or peas, lentils, soy beans, eggs, seeds, nuts, and nut butters (e.g., peanut butter).

These foods are important sources of protein, phosphorus, iron, vitamin B_6 and vitamin B_{12}. Only foods of animal origin contain vitamin B_{12} and cholesterol naturally.

Fats, Oils and Sugar

Include limited amounts depending on individual calorie needs. Sources include margarine, butter, vegetable oils, mayonnaise, salad dressing, and unenriched, refined baked goods.

These foods provide mainly calories. For example, unenriched, refined baked goods provide low levels of vitamins, minerals, and protein, compared to the calories they contain.

SNACKS

Snacks can be an important part of a well-balanced diet. For preschoolers, snacks are especially important since their stomachs are small and they usually can't eat enough in three meals to meet energy needs or satisfy appetites. Within about three hours after a meal, young children will usually be hungry. Foods eaten at snack-time can often provide nutrients missing from the rest of the day's food. The challenge is to help preschoolers eat nutritious snacks and to do so at appropriate times during the day. Good snacks are those that help provide children with essential nutrients they may be missing the rest of the day. They're also substantial enough to ward off hunger until the next meal. A small glass of juice or fruit can help tide children over when parents are getting dinner ready or they are on the way home from day care. A heavier snack, one containing protein, carbohydrate and fat, such as fruit, cheese and crackers or a small turkey, lettuce and tomato sandwich may be provided at day care when children have several hours before their next meal.

Snack traps are foods that provide too many calories without supplying their share of nutrients. They're the chips, candy, cookies, snack cakes, soft drinks--foods that are highly processed, rich in fat, sugar, and/or salt, and lacking in dietary fiber. Relying too much on "snack traps" can produce overweight children who are actually quite malnourished. "Empty calories" may meet or even exceed a person's energy needs, but won't meet the nutrients needed for growth and development.

For example, both a soft drink and a glass of orange juice provide about the same number of calories--160 per cup. The juice provides a full day's supply of Vitamin C as well as other important vitamins and minerals. The soft drink provides only calories, along with sugar, flavorings, colorings, and possibly caffeine. All too often these empty calorie foods fill the child up so that they are no longer hungry for more nutritious foods. That's why "treats" should stay "treats" and be served only once in while.

■ APPETITE

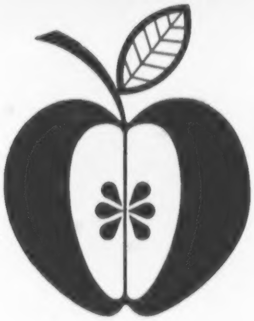
Preschoolers are not growing as fast as they were in infancy so their appetites decrease. A small appetite may also result if a child is overly tired, excited, ill, or in strange surroundings. Since no one food contains all the nutrients our bodies need, a variety of foods should be served, such as fruits, vegetables, protein foods, unsweetened cereals, etc. Preschoolers generally enjoy eating the same foods as adults. The Preschool Feeding Guide provides suggestions on the number of servings from each of the food groups that children should have daily (Appendix 16).

Preschoolers are famous for their unstable eating habits. A child may be less hungry because s/he is in a slow growth stage or practicing newly discovered independence. A child may begin eating more if s/he is not getting enough to eat at home. There are various reasons for a change in a child's appetite. Be aware of any change which lasts for longer than a few days and talk to parents or caregivers to try to find the reason.

■ FOOD HABITS -- VARIETY IS ESSENTIAL

As day care providers, you can help children develop good food habits by offering a wide variety of foods (both different foods and the same food prepared different ways, e.g., raw potato sticks, baked potatoes, potato salad). Gradually introducing a wide variety of foods increases food acceptance. This is especially

Figure 25
Ideas for Nutritious Snacks



Fruits and Vegetables

1. Keep 'em Fresh--apples, oranges, grapes, cherries, strawberries, blueberries, bananas, grapes, canteloupe, watermelons, grapefruit--etc., etc., etc.
2. Apple Sandwich--slice an apple, spread peanut butter onto slices, make a sandwich; or, fill "sandwich" with a slice of cheese.
3. Yogurt Sundae--Have kids make their own--just supply bowls, plain yogurt, cut-up fruit, and toppings of chopped nuts, sunflower seeds, wheat germ or dry cereal.
4. Fruit Kabobs--Skewer with a straw or long toothpick (for older children) cut-up pieces of fresh fruit and low-fat cheese cubes, pitted dates, or prunes. Serve with a "dip" of plain, low-fat yogurt with a sprinkling of cinnamon or a few drops of vanilla flavoring or a well-stirred mixed fruit yogurt.
5. Fruit Juice Surprise--Divide up one cup of cut-up fruit pieces (apple, banana, orange, strawberry, etc.) into four glasses, add 3 cups unsweetened fruit juice and chill.
6. Veggie Kabobs--Skewer (see above) cut-up pieces of fresh vegetables such as cherry tomatoes, zucchini, carrots, cucumbers, green peppers, mushrooms, and low-fat cheese cubes. Serve with salad dressing, or a dip made from mashed beans, yogurt, or cottage cheese seasoned with herbs.
7. Toss yourself a salad or invite kids to a home-made salad bar. Set out dishes of cut up veggies for children to create their own salads.
8. Celery Stuff-its--Fill celery with part skim ricotta cheese mixed with unsweetened crushed pineapple; or, fill celery with peanut butter and add a few raisins--we call this, "ants on a log".
9. Lettuce Stroll--Spread tuna or chicken salad, peanut butter, or low-fat ricotta cheese on a lettuce leaf, roll it up and eat.

Freezer Delights

10. Frozen Dixies--Freeze in paper cups with a popsicle stick one of these: applesauce, crushed pineapple, fruited yogurt (well mixed or fruit juices).
11. Frozen Strawberries Yogurt Pops--Blend 1 cup frozen strawberries until smooth. Add strawberries to 1 cup plain, low-fat yogurt, 3 to 5 tablespoons honey, and mix well. Pour into paper cups, with a popsicle stick in the center of each cup. Freeze one to two hours until firm. Remove cup from frozen yogurt and serve. Yield: 7 pops.
12. My Pop's Better Than Yours--Mix well 2 cups low-fat plain yogurt, 1 cup mashed banana, 1 tsp. vanilla, and 1/2 cup chopped walnuts (optional). Pour into six four-ounce paper cups, insert popsicle sticks in center for handles and freeze till firm. Remove cup and serve.

Figure 25 (cont.)

13. Banana Rockets--Coat peeled ripe bananas with orange juice or orange juice concentrate (to prevent browning), wrap in foil or plastic wrap and freeze. Optional--roll chilled OJ-covered bananas in chopped nuts or granola, pressing to coat, freeze till firm.

Blender Snacks

14. Blender Basics--1 cup of plain yogurt, 1 cup chopped fruit (strawberries, bananas, etc.) and 1/2 cup fruit juice (OJ, pineapple, grape, etc.). Note--frozen fruit makes shake thicker.

15. Melon Cooler--Mix in blender till smooth: 1 1/2 cups ice cubes, 1 1/2 cups cubed watermelon, honeydew or cantaloupe, and 1/2 tsp. lemon juice. Serve immediately. Yield: 2 1/2 cups.

16. The Ambrosia Shake--Mix in blender: 4 sliced ripe bananas, 1/2 cups orange juice, 1/4 tsp. vanilla, 4 cups low-fat or skim or reconstituted non-fat dry milk. Yield: 6 servings. Or,

17. Fruit Soup--Combine in blender: 1/4 cup orange juice, 1/2 small banana, 1/2 apple, 1 tsp. lemon juice, 2 Tbsp. plain, low-fat yogurt, 1/4 cup strawberries, dash of cinnamon, dash of dried mint. Chill before serving. Yield: 3 half cup servings.

Home-made Convenience Snacks

18. Train Mix--Combine, dried fruits, and dry cereal together and divide into plastic bags or dixie cups.

19. Cheese Popcorn--Make popcorn and sprinkle with grated parmesan cheese with or without melted butter or margarine.

20. Going Crackers--Crackers and cheese, crackers and peanut butter, crackers and peanut butter and jelly, crackers and dip--but choose your crackers well! Choices lower in fat and sodium include melba toast, matzoh, rice cakes, Wasa, Rye Krisp, Bread Sticks, Unsalted Saltines, Zwieback, and Graham Crackers.

21. Yummo Wrap-Ups--Have kids make their own--with flour tortillas and a spread of peanut butter, dried fruits, and raisins--great for hikes; or use part-skim ricotta chesse and cinnamon or jam.

22. Nachos--Cut corn tortillas into six triangles. Top with grated mozzarella cheese. Place in toaster oven or 350 oven to crisp tortilla and melt cheese. Serve with salsa.

23. Natural Soda Pop--Combine half a glass of fruit juice (i.e., orange, grape, apple, pineapple) with half a glass of club soda or seltzer, and ice and enjoy.

© Barbara Storper, Massachusetts Nutrition Resource Center--1-800-322-7203, 150 Tremont St., Boston, MA 02111, 1987

important during the early years when food likes and dislikes are being formed. Pay attention to what foods preschoolers eat and encourage them to eat foods from different food groups.

FOOD HABITS ARE LEARNED

Food habits and the ability to eat wisely are LEARNED! Children are great imitators and often mimic actions of people around them. Children's food habits, likes, and dislikes frequently reflect your own! Children can learn to accept foods you dislike, if you present them positively and take a few bites yourself.

INTRODUCING NEW FOODS

New foods will be accepted more readily if you follow the guidelines below:

- Introduce only one new food at a time.
- Serve the new food with familiar foods.
- Serve only small amounts of the new food -- begin with one teaspoon.
- Introduce new foods only when children are hungry.
- Talk about the new food -- taste, color, texture.
- Let children see you eat and enjoy it!
- Encourage children to taste the new food. If rejected, accept the refusal and try again in a few weeks. As foods become more familiar, they are more readily accepted.
- Find out what is not liked about the rejected food. Often the food will be accepted if it is prepared in a different way.

FOOD AS REWARD OR PUNISHMENT?

Sometimes we're tempted to use food as a reward, pacifier, or punishment. How many times have you said, "No dessert until you clean your plate," thereby implying desserts are a better part of the meal? Children do need positive encouragement, but using food as a reward places undue emphasis on certain foods. Praise, a smile, or a hug serve just as well. Avoid using food for reasons other than to satisfy hunger.

FOOD SAFETY

These suggestions should be followed to avoid food-related injuries:

- Don't serve nuts, popcorn, whole grapes, or chunks of hot dog to children under the age of four. If a child begins coughing while eating, a dangerous situation can arise. These foods can be easily aspirated (breathed into the lungs) and the child may choke. Hot dogs can be served if they are sliced lengthwise first and then cut into bite-sized pieces.

- Honey, a sweetener sometimes used in baby foods and formulas, should not be fed to infants under one year of age. Honey has been found to be a source of toxic bacteria which causes botulism in infancy.

- *At least one staff member should know how to remove food caught in a child's throat (to administer a modified Heimlich maneuver). It is common for children learning to eat finger foods to choke on an oversized piece. Immediate attention is required.*

ACTIVITY AND PHYSICAL EXERCISE

Activity has a lot to do with a child's appetite and nutritional status. Active children need more calories than inactive ones; this means that they have a better chance of getting all required nutrients. Adequate physical exercise year-round, preferably on a daily basis, is important to a child's development because it:

- stimulates healthy appetites
- uses calories and maintains muscle tissue
- improves coordination
- encourages children to express themselves and develop social skills

COMMON NUTRITIONAL CONCERNS

Fats

There is growing concern about the role of fat in heart disease and there is a controversy about the kind of fat and amount of cholesterol permissable in children's diets. Polyunsaturated and saturated fats are important nutrients to include in the proper ratio. Polyunsaturated fats are the liquid vegetable oils which contain essential fatty acids that the body cannot manufacture. Saturated fats are the solid fats found in beef, pork, lamb, chicken, cheese, whole milk, and other dairy products. Some fat from both sources is necessary to maintain the proper balance of fatty acids in the body. Foods such as hot dogs, luncheon meats and potato chips are high in fat and salt and should be limited in a preschool child's diet.

Sugar: Friend or Foe?

Sugar is easy to avoid when a child is small and doesn't miss it. There is really no reason to sweeten food. Honey, in any form, should be avoided in the first year of life as it can cause botulism, a toxic condition for infants. Honey, molasses, raw sugar, and refined sugar all contain the same amount of calories. Sweetener should never be added to vegetables, fruits, fruit juice, or cereal. "Empty calorie foods" such as candy; sweetened, carbonated beverages; and unenriched, refined, sweetened baked goods provide mainly calories and low levels of essential nutrients. Foods with a high sugar content should be limited both to avoid unnecessary calories and for good dental health. (See Chapter 11.)

Salt: Why the Concern?

High salt diets may affect the development of high blood pressure, especially in people with a family background of hypertension (high blood pressure).

Salt intake can be reduced by removing the salt shaker from the table, decreasing the amount of salt used in cooking, and limiting the amount of salty foods (pickles, canned soups, chips, salty crackers, and salted nuts). Don't overlook the hidden sources of salt found in hot dogs, bacon, sausages, canned or some frozen foods. Since preference for salty foods is learned, it can be changed.

Vegetarian Diets

A well-planned vegetarian diet can provide all the nutrients a child needs for growth and activity. Vegetarian diets are often high in fiber and low in cholesterol and saturated fat, and they have many positive health benefits. Vegetarian diets may include different food restrictions. The following chart describes vegetarian eating patterns.

Types of Vegetarian Diets and Foods Consumed
(Adapted from Ivens and Weil)

	Beef and Pork	Fish and Poultry	Milk and Milk Products	Eggs	Vegetables and Fruits, Cereals, and Breads, Nuts
Traditional Diet	X	X	X	X	X
Semi-Vegetarian		X	X	X	X
Lacto-Ovo Vegetarian			X	X	X
Ovo-Vegetarian				X	X
Lacto-Vegetarian			X		X
Vegan (Total Vegetarian)					X

For example, the semi-vegetarian avoids red meat only; the lacto-ovo vegetarian eats eggs and dairy products and avoids meat, fish, and poultry; the lacto-vegetarian eats dairy products and avoids meat, fish, poultry and eggs; and the vegan or total vegetarian avoids all animal products.

Vegetarian diets that include dairy products and eggs readily provide all the needed nutrients for preschool children. Vegan or total vegetarian diets that omit all animal protein can be nutritionally inadequate and may not provide enough protein, calcium, iron, zinc, vitamin D, and vitamin B_{12}. These very strict vegetarian diets may also be low in calories due to their high bulk and their low fat content. In addition, problems of short stature and rickets have occurred in children on very restrictive vegetarian diets.

Legumes, seeds or nuts, when combined with grains, provide a good protein source. But to get enough protein, children on vegan or strict vegetarian diets need to eat a larger volume of food than children who eat meat, fish, poultry, and cheese. The number of servings from each food group will be different for a child eating a vegetarian diet, particularly a vegan diet. Parents who wish to have their children follow a vegan diet should be referred to a dietitian or nutritionist to ensure that intake of nutrients and calories is adequate for their child's growth.

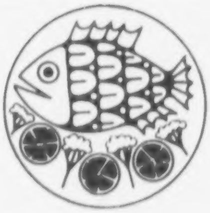
Milk: What Is the Right Amount?

Some preschoolers drink too much milk, and some don't drink enough. If children drink too much milk, they may spoil their appetites for other foods. Some children may develop iron deficiency anemia because they drink too much milk and don't eat enough of other foods. (See p. 176.) Offer water if a child is thirsty. If a preschooler doesn't drink enough milk, try not to make a big deal of it since this is probably just a phase. Left alone, the child will probably go back to drinking milk. A preschool child needs approximately 16 to 24 ounces or two to three cups of milk daily. Other foods rich in calcium, such as hard cheese and yogurt, can be substituted for milk (See Figure 26).

Special Nutritional Problems

Day care centers must provide special diets for children who require them. The day care center must follow orders of parents or the physician in preparing and feeding the special diet to the child. A nutritionist should be consulted for assistance in menu planning for children who require special diets.

Figure 26
Dietary Sources of Calcium



EXCELLENT (250-400 mg. calcium per serving)

8 oz. yogurt, low fat or whole milk, plain or fruit flavored
8 oz. skim milk
8 oz. lowfat milk, one or two percent
8 oz. buttermilk
8 oz. whole milk
1 oz. swiss cheese
3 oz. sardines, canned with bones

GOOD (150-250 mg. calcium per serving)

1 oz. cheeses: cheddar, muenster, mozzarella, blue
1 oz. cheese food: American or Swiss pasteurized process
1 tablespoon parmesan cheese, grated
4 oz. tofu*
1/4 cup, dry skim milk, instant
3 oz. mackerel, canned, solids and liquids
3 oz. salmon, pink, canned with bones
1/2 cup collard greens, cooked

FAIR (50-150 mg. calcium per serving)

1 tablespoon blackstrap molasses
1/2 cup ice milk, vanilla, soft serve
5 medium figs, dried
1/2 cup kale, cooked
1/2 cup mustard greens, cooked
1/2 cup ice cream, vanilla
2 medium corn muffins
1/2 cup chick peas, cooked
1/2 cup broccoli, cooked
1/2 cup cottage cheese, creamed

---

*Calcium content of tofu will differ according to the processing method. Tofu contains calcium if it is processed with a calcium coagulant such as sulfate. Look on the nutrition label or in the ingredient list. Nigari is a popular tofu coagulant which does not contain calcium.

■ OBESITY

Obesity is a complex problem with multiple causes including overeating, poor food choices, inactivity, social or emotional factors, and genetics. Many obese children will remain so throughout life. Obesity can significantly affect a child psychologically and emotionally, and can result in poor self-esteem and negative self-image.

Many young children learn eating and activity patterns that can lead to obesity later in life. Using food as a reward or pacifier, force feeding, or providing very large portions and membership in the "Clean Plate Club" may contribute to obesity. Physical activity is essential to maintain a normal weight. Surprisingly, it is often inactivity rather than calorie intake that causes obesity.

The goal of weight management for children is to *limit further weight gain.* Children will grow slimmer as they "grow into their weight." Actual *weight loss is not generally recommended* as children need adequate nutrients and calories for growth. Low fat, nutritious meals and snacks are essential to good weight management.

Management/Prevention

- Encourage children to be physically active.

- Exercise is fun, reduces stress and uses calories.

- Discourage too much TV watching which after results in too much snacking and not enough exercise. Also TV ads promote foods that are highly processed and rich in fat, calories, sugar and salt.

- Limit high calorie foods (foods high in fat, sugar or both; i.e., potato chips, candy, cakes).

- Limit excessive drinking of sweetened beverages such as fruit drinks, powdered or syrup-based drink mixes, and chocolate milk which can add many extra calories each day. A child's thirst can be satisfied with water after the proper amount of milk has been consumed.

- Use low fat or skim milk with children over two years old.

- Help children learn to deal with emotions or stress without turning to food.

- Remember your food habits and attitudes will influence those of the children around you.

■ ANEMIA

Iron is needed to form hemoglobin, the substance in blood which carries oxygen from the lungs to the body cells. Without enough iron, our blood cannot carry the oxygen our bodies need. Lack of iron results in anemia. An anemic child is likely to appear tired, pale, and inattentive.

Iron deficiency anemia is a common problem for preschool children, particularly for children from low income families. There are several reasons for this.

1. Overconsumption of milk (more than 24-32 ounces per day) results in low intake of other foods, particularly iron-containing foods.

2. Few foods contain iron in large amounts, and it is difficult for young children to get all the iron they need.

3. Lack of high-iron, high-nutrient foods served for snacks. Frequently, snacks provide calories with few other nutrients.

4. Lead toxicity. Iron deficiency and lead poisoning frequently occur together. Iron and lead compete with each other for the same binding sites in the body. Iron deficiency may increase the absorption of lead from the intestine and make the toxic effects of lead worse. Therapeutic doses of iron are often required to correct the iron deficiency when accompanied by lead poisoning.

Management

1. Encourage the child to consume a varied, well-balanced diet which includes iron-rich foods.

2. Provide increased amounts of iron-rich foods at meals and snacks. Good sources of iron include liver, dry beans and peas, lentils, beef, pork, lamb, whole wheat and enriched breads, and cereal products. Raisins and peanut butter also contain iron. Iron from animal sources is absorbed better than iron from plant sources.

3. Serve iron-rich foods with a source of vitamin C. Vitamin C increases the body's ability to use iron. The amount of iron absorbed from plant sources can be increased significantly when these foods are combined with a food high in vitamin C. For example, serve spinach, broccoli, or tomato slices with chili; serve half an orange, cantaloupe cubes, or strawberries with split pea soup. These fruits and vegetables provide fiber and

vitamin C as well as make the iron in the bean dishes more available for use by the body.

4. Limit milk to 24 ounces per day and assure adequate intake of other foods, particularly iron-containing foods.

FAILURE-TO-THRIVE

Some children do not grow properly. They are small or thin for their age; their height may be low for their age, or their weight may be low for their height. They may tire easily, be inattentive, disinterested in eating, and be undernourished. This complex syndrome known as Failure-to-Thrive (FTT) may be due to medical, nutritional, or psychosocial factors.

Management

1. Refer the child immediately for a complete medical, nutritional, and social evaluation.

2. A nutritionist should be consulted to plan a nutritionally appropriate diet and support the family, child, and day care providers during the critical period of weight gain.

3. You may need to assist the family with carrying out the recommended treatment plan.

4. Children who fail to thrive need to be watched closely, even when the crisis is past.

FOOD ALLERGIES AND INTOLERANCES

Infants and young children often have food allergies or are intolerant of certain foods. An allergic reaction occurs when a child becomes sensitive to a particular food and the immune system produces increased amounts of antibodies. The allergic reaction can be avoided only by avoiding the food. Foods that commonly cause allergic reactions are nuts, peanuts, eggs, cow's milk protein, wheat, fish, shellfish, and citrus fruits. A food intolerance means that the child has some metabolic factors (e.g., does not manufacture a enzyme or chemical needed to digest a certain food substance) which make it difficult or impossible to digest or use that food. Sometimes, foods can be modified so that the child can tolerate them. Intolerance to the sugar in cow's milk (lactose) is a common problem in infants and children. (See section on Lactose Intolerance below.) Soy formulas are frequently used alternatives to cow's milk or regular formula for children with either milk allergies or lactose intolerance.

When the allergic child eats a food which s/he is sensitive to, symptoms such as diarrhea, vomiting, abdominal pain, rash, irritability or hyperactivity may occur. Reactions may be immediate or delayed; symptoms may be mild to severe, depending on the type and amount of food eaten and the age of the child.

Management

1. Consult a nutritionist concerning diet planning for the allergic child.

2. Eliminate or decrease the problem food(s) from the diet depending on the severity of the reaction.

3. Read labels to identify hidden sources of the problem foods or substances.

4. Work with parents to find acceptable substitutes for problem foods.

5. Plan menus carefully to ensure adequate nutrition, particularly if a child has multiple food allergies, or if the child is allergic to major food groups.

6. Make sure the child gets critical nutrients from other sources: calcium and vitamin D if child is allergic to milk; vitamin C if child is allergic to citrus fruits.

■ LACTOSE INTOLERANCE

Some children are unable to digest the sugar in milk, called lactose, due to a low level of the enzyme lactase in the intestine. Children with lactose intolerance may suffer from abdominal pain, bloating, and diarrhea. Lactose intolerance is very common in Africans, Black Americans, Orientals, Jews, Arabs, and Indians (North and South American).

Management

Tolerance of lactose varies. Many children can tolerate small amounts of lactose (e.g., 8 oz. of milk) if intake of these foods is spaced throughout the day. Encourage children to try cheese and other fermented dairy products such as yogurt which have a lower lactose content and are better tolerated. Lactose-free, soy-based formulas are available as substitutes for regular infant forumla or cow's milk. Encourage parents to try hydrolyzed milk (milk in which the lactose has been made more digestable by the enzyme lactase). You can buy hydrolyzed milk in many stores (brand name: Lact-aid Milk). Lact-aid, the commercial name for the lactase enzyme, is also available separately to be added to regular milk for the same effect. (See Figure 26 for alternative calcium sources.)

The diet of a child on a lactose-restricted diet should be evaluated regularly. Because calcium requirements are met primarily through eating dairy products, children with lactose intolerance may not get adequate calcium.

■ HYPERACTIVITY

Additive-free diets for the treatment of hyperactivity have questionable value. Diets that eliminate artificial food colorings and salicylates (aspirin-like compounds) are not harmful to children and may have the effect of improving the nutritional value of the child's diet. However, they have not been shown to affect the hyperactivity itself. Any such diet, therefore, should be carefully planned along with appropriate medical and psychological treatment. A nutritionist should be consulted to ensure nutritional adequacy.

Feeding Children with Handicapping Conditions

■ GENERAL INFORMATION

Children with handicapping conditions have the same needs as all children for care and feeding. Often these basic needs are overlooked in the concern for the child's disability or handicapping condition. Nutritional problems such as poor food intake, inability to chew or swallow normally, inadequate weight gain, short stature, obesity, iron deficiency anemia, and behavioral problems associated with eating are frequently part of handicapping conditions; these problems cause a child to be at nutritional risk. Infants or children with handicapping conditions may have feeding needs which require more patience, time, and understanding than usual.

Whatever the disease or disorder, the child's growth and development to his/her full potential must be promoted. Good nutrition always contributes to optimal growth and development and can decrease or prevent the debilitating effects of many handicapping conditions.

As a day care provider, you will need to be especially careful that the child is getting adequate nutrients. Children with handicapping conditions may require extra time to eat and should not be hurried. They may also need the encouragement provided by eating with other children and staff. In addition, special equipment may be required.

Day care centers should utilize the services of a nutritionist or dietitian to ensure that families and staff have the knowledge, skills, and support to provide optimal nutritional care to the child with a handicapping condition. If necessary, involve occupational and physical therapists, social workers, or other health providers to help solve any complex problems which arise.

When you are caring for children with delayed feeding skills, chewing and/or swallowing difficulties, allergic conditions, or metabolic disturbances requiring special diets, you should consult the nutritionist or dietitian caring for the child or make a referral. The nutritionist can evaluate the child's nutritional needs and set appropriate nutritional goals for calories, nutrients, textures, and acquisition of self-feeding skills. Special adaptive equipment also may be identified. The nutritionist can help you develop a flexible plan for meals and snacks which takes into account the child's food likes and dislikes and eating style.

If a child has delayed feeding skills, it will take longer to bring the child through the steps of sucking, swallowing pureed foods, and chewing and swallowing more solid food. You should concentrate on creating a pleasant eating environment where the child can learn to eat in a manner appropriate to his/her developmental level. It is essential to involve parents in meeting the special nutritional needs of the child with a handicapping condition, since the major part of the child's food needs must be met at home.

■ SPECIAL NUTRITIONAL CONCERNS

Obesity

Obesity is a common nutritional problem in many handicapping conditions. Growth deficits, metabolic factors, psychological problems, and lack of activity all contribute to obesity. Prevention is especially important since obesity is difficult to reverse once it is present. Treatment for obesity should include a calorie-controlled diet, physical activity, and behavior modification. A nutritionist can help you plan a reduced calorie diet. By reinforcing appropriate eating behavior through nonfood rewards, you can help the child learn to control the types and quantities of foods consumed. Increased physical activity can help utilize calories, improve muscle tone, and relieve tension. Parents, health care providers, you, and the child all need to be involved.

Underweight

Some children with handicapping conditions are underweight. The causes of underweight include genetic leanness, increased metabolic demands from the underlying disease, inadequate food intake, delayed self-feeding, increased activity, pain, fatigue, or vomiting. Nutritionists can be helpful in determining the causes of underweight as well as in developing treatment plans. When conventional foods do not meet a child's nutritional needs, special dietary supplements may be used. These oral supplements provide nutrients and calories in addition to the regular diet. If a child is not eating well, encourage parents to consult a nutritionist about a nutritional supplement for the child. Supplements need not be expensive and can help a child gain weight in order to grow and develop properly.

Behavioral Problems

Occasionally, children with handicapping conditions develop behavior problems involving eating. These include problems with food acceptance, holding food in the mouth, eating nonfood items, and hyperactivity. Sometimes they stop eating completely. Discuss these problems with parents immediately and involve appropriate health care providers to develop a workable treatment plan.

Inborn Errors of Metabolism

A child with phenylketonuria (PKU) or any other inborn error of metabolism needs to be on a carefully controlled diet in order to promote normal growth and development and ensure intake of adequate nutrients. For the most part, food for the child's meals and snacks should be provided by the family. Other children should not share their food.

Other Metabolic Problems

Conditions such as diabetes require only minor changes in the day care center's menu. A meal plan to be used as a guide should be provided by the parents or a nutritionist.

Nutrition Education

Childhood is the best time to develop good food habits since early experiences with food have a strong impact on a child's future eating habits and health. Diet has been associated with the development of many of the major chronic diseases in the country: heart disease, stroke, high blood pressure, some forms of cancer, diabetes, and tooth decay. Nutrition education can also significantly enrich the lives of children and provide a means for learning about their life and culture. Children who understand themselves and their environment develop a positive self-image, an essential ingredient for effective learning of any kind. Nutrition education teaches young children how to be selective about food and combats misinformation from television advertising.

Dietary habits are established early in life. The habits children learn during the preschool years will affect future health.

DIETARY GUIDELINES FOR ALL AGES

The U.S. Department of Agriculture and the Department of Health and Human Services have published dietary guidelines intended to promote the health of all Americans. They should form the basis of any nutrition education activities you conduct for children, staff, or parents. These guidelines are:

Eat a variety of foods.

- Infants and toddlers have special nutritional needs and need less variety.
  - Encourage breast feeding unless there are special problems.
  - Delay introduction of solids until baby is four to six months old.
  - Do not add salt or sugar to child's food.

Maintain desirable weight.

Avoid too much fat, saturated fat and cholesterol.

- Choose lean meat, fish, poultry, and dry beans and peas as protein sources.

- Use skim or lowfat milk and milk products (after 18-24 mos. of age.)

- Limit intake of fat and oils, especially those high in saturated fat such as butter, cream, lard, hydrogenated fats (some margarines), shortenings and foods containing palm or coconut oil.

- Trim fat off meats.

- Broil, bake, or boil rather than fry.

- Moderate the use of foods that contain fat, such as breaded and fried foods.

- Read labels carefully to determine both the amount and type of fat present in foods (e.g., choose margarines with liquid vegetable oil as the first ingredient).

Eat foods with adequate starch and fiber.

- Choose foods that are good sources of fiber and starch, such as whole grain breads and cereals, fruits and vegetables, and dry beans and peas.

- Substitute starchy foods for those that have large amounts of fats and sugars.

Avoid too much sugar.

- Use less of all sugars and foods containing large amounts of sugars, including white sugar, brown sugar, raw sugar, honey, and syrups.
- Read labels for clues of sugar content. If the names sugar, sucrose, glucose, maltose, dextrose, lactose, fructose, or syrup appear first or frequently, then there is a large amount of sugar.
- Select fresh fruit or fruits processed without syrup or with light rather than heavy syrup.
- Limit how often sugar and sugar-containing foods are eaten for good dental health. Avoid eating sweets between meals.

Avoid too much sodium (salt).

- Cook without salt or with only small amounts of added salt.
- Try flavoring foods with herbs, spices, and lemon juice.
- Add little or no salt to food at the table.
- Limit use of salty foods such as potato chips, pretzels, salted nuts and popcorn, condiments (soy sauce, steak sauce, garlic salt), pickled foods, cured meats, some cheeses, and some canned vegetables and soups.
- Read food labels carefully to determine the amounts of sodium.
- Use lower sodium products, when available, to replace those you use that have higher sodium content.

If you drink alcoholic beverages, do so in moderation.

■ NUTRITION EDUCATION WITH CHILDREN

Teaching preschoolers to eat wisely and moderately is an investment in the future. The foods children eat influence their growth, development, capacity to learn, and overall behavior. All children deserve an equal opportunity to learn about foods, to explore different foods, and to learn why eating a varied, nutritionally adequate diet is necessary to reach one's growth potential. Social, economic, cultural, and psychological factors play an important role in determining what and how much we eat. Successful nutrition education helps children develop flexible, enjoyable, healthy eating habits.

Figure 27 identifies ideas for nutrition education which will foster the development of positive eating practices as well as enhance a child's emotional and psychological growth. These

Figure 27

Food and the Child: Ideas for Nutrition Education

DEVELOPMENTAL AREAS	KNOWLEDGE/SKILLS USED	ACTIVITY
Good Self-Image	Develop skills to choose foods wisely	Have children plan, prepare, and serve simple nutritional snacks. For example, have children prepare "Ants on a Log"--celery stuffed with peanut butter and raisins.
Appreciation of Health	Gain knowledge of how food promotes growth and development	Children view filmstrip "Toothtown USA" and discuss what foods help their teeth grow and stay healthy.
Enjoyment of Food Through All the Senses	Experience various foods through sight, sound, smell, feel, and taste	Children will try to identify a banana using one sense (sound, smell, feel, touch) at a time and check their answers through sight.
Appreciation of Ethnic Heritage	Share cultural background	The cultural heritage of one or more children is chosen as a theme for a day's meals and snacks. Discuss at mealtimes how factors such as climate and history help shape food habits.
Self Expression	Foster creativity	Have children try various whole grain breads by first baking the bread and then tasting it. Encourage children to shape the dough in different ways.

learning experiences can be easily integrated into usual routines at the day care center. For example, eating together at meal and snack time or during special occasions is an opportunity for children to socialize. Visits to local farms and farmer's markets will put children in touch with local surroundings and create an awareness of how food is grown and sold in places different from a supermarket.

The cultural and ethnic customs of our society influence the food we eat. Cultural heritage often determines whether a particular food will be eaten, regardless of its nutritional value. A wide variety of cultures and food habits can make eating interesting and fun.

INVOLVING PARENTS

You can't be the only advocate of good nutrition; parent involvement is essential. A combination of foods eaten at home and in day care should provide all the necessary nutrients for a child. Parents and day care providers need to educate themselves about the types and amounts of food necessary for good nutrition.

Suggestions for Involving Parents

- Ask parents to assist in planning menus. The day care center might provide an educational meeting to teach parents the principles of good nutrition involved in menu planning for preschool children.

- Include articles in your newsletter about nutrition education activities at the center. Ask parents for ideas for future programs and invite parents to participate in actual classroom activities. Ask parents to contribute articles to the newsletter about nutrition activities with their children at home.

- Send menus home with children to show parents what meals and snacks are planned. Offer parents new ideas for providing nutritious foods at home. Ask parents to share creative meal and snack ideas with each other. Have a contest for the best idea.

- Invite parents to visit and participate with their children at a "pot luck" dinner with a special ethnic food unique to their culture.

- Talk with parents about any eating or nutritional problems you notice. Make appropriate referrals and provide regular progress reports.

- Sponsor educational programs for parents on nutrition and consumer issues. Help parents understand how they can reinforce positive eating habits at home. Use the Dietary Guidelines as a starting point.

- Make available a list of community food and nutrition services including school feeding programs, food stamps, WIC (Supplemental Food Program for Women, Infants and Children) and emergency feeding agencies.

- Tell parents about ways to involve their child with food in the home such as:
  - Allow your child to help prepare food.
  - Let the child share in clean-up activities.
  - Encourage your child to talk with you about food.

Food Service

■ MENU PLANNING

Menus should be planned around the nutritional and developmental needs of preschoolers. The meal pattern developed by the USDA Child Care Food Program (CCFP) should be used as a minimum standard. (See Figure 28.) Appendix 17 includes three sample weekly menus as examples of how to translate the menu pattern into actual meals and snacks. If all the food groups are not represented at one meal, serve the missing one at snack time.

Provide preschoolers with nutritious foods they like and can eat easily. Fibrous or dry foods are difficult for young children to eat. Foods should be soft and moist. Preschoolers usually do not like food that is very hot or very cold. Cut foods into bite-size pieces. Serve a variety of finger foods or foods that can be easily picked up. In cooking, try to preserve natural colors and textures so food looks appealing.

Written menus must be prepared weekly, maintained, and posted by each day care center. Nutritious snacks must be provided mid-morning or mid-afternoon for children attending day care for less than four hours, and meals in addition to snacks must be provided by the program or parents for children attending four hours or longer.

A menu-planning form should be used so that there is consistency in each day's menu. A sample menu-planning worksheet is shown in Figure 29 to assist you in planning varied, nutritious meals.

A menu planning committee is one suggestion for involving interested people in developing your program's menu. A menu planning committee might consist of:

- the program director
- teacher or teacher's assistant
- cook
- parents
- nutritionist

Each of these people can contribute critical information to the development of the menu. If you use cycle menus you may only have to meet once a month or every six weeks.

The actual operation of a food service program involves a number of issues related to environmental health, sanitation, and infectious disease control. See Chapters 3, 4 and 17 for further information and guidelines.

Present Inventory

Keeping an inventory of the foods on hand will help you determine how much of a particular food you need to order.

Budget

The budget is an important factor in planning a menu. If your program is not being reimbursed for meals through the Child Care Food Program (CCFP), your food costs will be a large part of your overall budget. Consider shopping at food cooperatives, using commodities, or shopping at food banks. There are three food banks in Massachusetts. See pages 199 for the location of the food bank nearest to you.

Availability of Equipment

The availability of equipment must be considered when planning menus. Ask the following questions: Is the oven large enough to accommodate the amount of food to be baked? Is there enough room in the refrigerator to store foods which spoil easily?

Availability of Storage Space

Check the availability of storage space before you plan the menu. Is there enough dry storage space for the number of cases of dry goods you'll need to order?

Figure 28

Child Care Program: Meal Pattern Requirement

BREAKFAST	Children 1 and 2 Years	Children 3 Through 5 Years	Children 6 Through 12 Years
Milk, fluid	1/2 cup	3/4 cup	1 cup
Juice or fruit or vegetable	1/4 cup	1/2 cup	1/2 cup
Bread and/or cereal,			
Bread, enriched or whole grain,	1/2 slice	1/2 slice	1 slice
or Cereal: Cold dry or	1/4 cup[1]	1/3 cup[2]	3/4 cup[3]
Hot cooked	1/4 cup	1/4 cup	1/2 cup
MIDMORNING OR MIDAFTERNOON SNACK (SUPPLEMENT)			
(Select 2 of these 4 components)			
Milk, fluid	1/2 cup	1/2 cup	1 cup
Meat or meat alternate	1/2 ounce	1/2 ounce	1 ounce
Juice or fruit or vegetable	1/2 cup	1/2 cup	3/4 cup
Bread and/or cereal			
Bread, enriched or whole grain	1/2 slice	1/2 slice	1 slice
or Cereal: Cold dry or	1/4 cup[1]	1/3 cup[2]	3/4 cup[3]
Hot cooked	1/4 cup	1/4 cup	1/2 cup
LUNCH OR SUPPER			
Milk, fluid	1/2 cup	3/4 cup	1 cup
Meat or meat alternate			
Meat, poultry, or fish, cooked (lean meat without bone)	1 ounce	1-1/2 ounces	2 ounces
Cheese	1 ounce	1-1/2 ounces	2 ounces
Egg	1	1	1
Cooked dry beans and peas	1/4 cup	3/8 cup	1/2 cup
Peanut butter	2 tablespoons	3 tablespoons	4 tablespoons
Vegetable and/or fruit (2 or more)	1/4 cup	1/2 cup	3/4 cup
Bread or bread alternate, enriched or whole grain	1/2 slice	1/2 slice	1 slice

---

[1] 1/4 cup (volume) or 1/3 ounce (weight) whichever is less.
[2] 1/3 cup (volume) or 1/2 ounce (weight) whichever is less.
[3] 3/4 cup (volume) or 1 ounce (weight) whichever is less.

Figure 29

Menu Planning Worksheet

USDA Child Care Food Program Snack and Meal Pattern	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
BREAKFAST Milk Fruit and/or Vegetable Bread or Cereal					
MORNING SNACK Serve any two of the following foods: Milk Fruit and/or vegetable Bread or bread alternate Meat or meat alternate					
LUNCH OR SUPPER (Circle one) Meat or meat alternate Vegetable and/or fruits (2 or more) Bread or bread alternate Milk Other foods					
AFTERNOON SNACK (Serve any two of the following foods) Milk Fruit and/or vegetable Bread or Bread Alternate Meat or Meat Alternate					

Cultural Diversity

Serving foods that represent different cultural food patterns and are familiar to children will help providers establish a rapport with the child and family. It also serves as a way to educate children about various cultures and their food preferences.

Season of the Year

Some foods are more available during various times of the year. This is particularly true of fruits and vegetables. Plan your menus to include fruits and vegetables that are in season. They are more economical and taste better.

■ GUIDE FOR FOOD PREPARATION AND SERVICE

This guide is intended to cover the required procedures for food preparation and service in day care. It is suggested that this guide be used as a working manual by cooks and others involved with food service. Chapter 4 on Sanitation should also be consulted for further information.

Food Purchasing

1. Suppliers of food and beverages must meet local, state, and federal codes. Each day care center that provides meals for thirteen or more children must be inspected by the local Board of Health and comply with Article X of the state Sanitary Code.

2. Meats and poultry must be inspected and passed for wholesomeness by federal or state inspectors.

3. Milk and milk products must be pasteurized. If dry milk is used, it must be prepared in a sanitized container and refrigerated or used immediately.

4. Home canned foods should not be used.

Food Storage

1. All perishable foods must be stored at temperatures which will prevent spoilage: refrigerator temperature, 45° F or below; freezer temperature, 0° F or below.

2. Thermometers must be located in the warmest part of the refrigerator and freezer (e.g., near the door), and should be checked daily.

3. Refrigerators must have enough shelf space to allow for air circulation around shelves and refrigerator walls to maintain proper food temperatures.

4. Food should be examined when brought to the center to make sure it is not spoiled, dirty, or infested with insects.

5. Unrefrigerated foods must be stored in *clean*, rodent- and insect-proof *covered* metal, glass, or hard plastic containers. (Large shortening cans available from bakeries are ideal for storing flour and other commodities.)

6. Containers of food should be stored above the floor (about six inches) on racks or other clean slotted surfaces which permit air circulation.

7. Storerooms must be dry and free from leaky plumbing or drainage problems. All holes and cracks in storerooms should be repaired to prevent insect and rodent infestation.

8. Storerooms should be kept cool (about 60° F) to increase shelf life.

9. All food items should be stored separately from non-food items.

10. An inventory system should be used to be sure that stored food is rotated. (The first food stored is the first food used.)

Preparing and Handling Infant Formula and Foods Sent From Home

Breast milk or formula may be sent to the day care center from home. *Breast milk* already in the infant's bottle should be marked with the date and the child's name. It may be stored in the refrigerator for up to 24 hours. *Concentrated infant formula* may be sent to the day care center in its original container. It is usually reconstituted one part water to one part formula, unless otherwise noted. *Ready to feed infant formula* does not need anything added to it. Parents of infants requiring a special formula should provide clearly written instructions for its preparation. Leftover milk in a bottle offered to a child should be discarded. In order to save as much breast milk or formula as possible, pour out from the container only the amount you think will be needed. You can always pour out more if necessary. Return unused breast milk or formula to the refrigerator immediately after the meal. Unused previously frozen breast milk cannot be refrozen. Before handling breast milk or infant formula, remember to wash your hands and utensils.

Commercially prepared strained and junior foods should not be fed directly from the jar. A serving should be removed from the jar and placed in a clean dish. Opened jars of baby food should be covered, dated, and refrigerated. The contents should be used within 48 hours.

Food Preparation and Handling

1. All raw fruits and vegetables should be washed before use. Tops of cans should be washed before opening.

2. Frozen foods that must be thawed before preparation should be thawed in the refrigerator, or quick-thawed in plastic bags under cold running water for immediate preparation. DO NOT thaw by allowing to stand at room temperature.

3. A thermometer should be used to check internal temperatures of the following foods to be sure they have been cooked evenly.

    - Stuffings, poultry -- heated to a minimum temperature of 165° F. (NOTE: Poultry should *not* be stuffed; cook dressing in a separate pan.)

    - Pork and pork products -- minimum of 160° F.

4. Meat salads, poultry salads, potato salad, egg salad, cream-filled pastries and other potentially hazardous prepared food (containing milk, meat, poultry, eggs, fish products) should be prepared from chilled products as quickly as possible and refrigerated in shallow containers or served immediately.

5. Keep cold foods cold (45° F or below) and keep hot foods hot (cook and hold at 140° F or above). Bacteria multiply most rapidly at temperatures between 45° and 140° F. All potentially hazardous foods must be maintained below 45° F or above 140° F during transportation and while holding until service.

6. Foods must also be covered or completely wrapped during transportation.

7. A spoon which has been used even once for tasting food should not be reused.

8. Provide each serving bowl on tables with a spoon or other utensil for serving food.

9. Leftover food from serving bowls on the table should be thrown out. Exceptions may be made for raw fruits and vegetables which can be thoroughly washed again or packaged foods which don't spoil. Food prepared to offer seconds can be held in the kitchen at safe temperatures for refilling serving bowls as needed.

10. Food held in the kitchen at proper temperatures may be reused.

11. Foods to be stored for reuse should be placed in shallow pans and refrigerated or frozen immediately to rapidly bring temperature down to 45° F or below.

12. Leftovers or prepared casseroles should not be held in the refrigerator over two days.

13. Leftover foods should not be sent home with children or adults because of the hazards of bacterial growth.

Storage of Nonfood Supplies

1. All cleaning supplies (including dish sanitizers) and other poisonous materials must be stored in *locked* compartments or in compartments well above the reach of children and separate from food, dishes, and utensils.

2. Poisonous and toxic materials, other than those needed for kitchen sanitation, should be stored in locked compartments outside the kitchen area.

3. Insect and rodent poisons should be stored in locked compartments in an area apart from other cleaning materials to avoid contamination or mistaken usage.

4. All containers of poisonous material should be clearly labeled as poison.

Cleaning and Care of Equipment

1. A cleaning schedule should be followed to prevent contamination of food. Suggested schedule:

    - Floors should be wet-mopped daily; scrubbed as needed.

    - Food preparation surfaces should be washed and sanitized between preparation of different food items (as between meat and salad preparation) or between different meats (e.g., chicken and pork).

    - Cutting board should be made from a hard nontoxic material (not wood), which is smooth and free of cracks, crevices and open seams.

    - After cutting *any single* meat, fish or poultry item, the cutting board *must* be thoroughly washed and sanitized (not just rinsed or wiped) before another item is cut.

- Can openers should be washed and sanitized daily.

- Utensils should be cleaned and sanitized between use on different food items.

2. Dishwashing should be by an approved method. (See Chapter 4.)

3. Range tops should be washed daily and as needed to keep clean during preparation.

4. Ovens and overhead hoods should be cleaned weekly or more often if needed.

5. Refrigerators should be washed with 1 1/2 oz. bleach/gal. water at least once a week. They should be defrosted when there is about 1/4 inch thickness of frost.

6. Tables and other eating surfaces should be washed and disinfected with the recommended bleach solution before and after each meal.

7. All food contact surfaces must be *air-dried* after cleaning and sanitizing. Do not use wiping cloths.

8. Do not use cracked or chipped dishes and utensils because they may harbor bacteria. Avoid utensils with chipped or painted handles.

9. No food contact surfaces should be made of cadmium, lead, zinc, granite enamelware, or other toxic materials.

10. Cyanide silver polishes or cleaners should not be used.

11. Garbage cans should have tight-fitting lids and should not leak.

12. Garbage cans should have plastic liners and should be emptied and cleaned frequently. The garbage area should be kept clean at all times.

13. There should be a sufficient number of garbage cans to hold all garbage.

Insect and Rodent Control

1. Only an approved pyrethrin-base insecticide or flyswatter may be used in the food preparation areas. Products should be used in accordance with directions and cautions appearing on their labels. The insecticides must not come in contact with raw or cooked food, utensils or equipment used in food preparation and

serving, or with any other food contact surface. ("No-pest" strips hanging from the ceiling are not acceptable.)

2. Doors and windows should have screens in good condition. Screens should be closed at all times. All openings to the outside should be closed or properly screened to prevent entrance of rodents or insects.

3. Insecticides for crawling insects should be applied only by certified personnel. A staff member should monitor where they apply the insecticides to be certain that food preparation surfaces or child contact areas are not contaminated.

Community Nutrition Resources

Knowing the nutrition services available in your community will help you promote good nutrition. A resource list of community nutrition programs, local nutritionists with whom you can consult, and emergency food agencies will help you make appropriate referrals when necessary. You might want to refer a parent or family to a food assistance program they may be eligible for but unaware of. You should consult a nutritionist for help with menus, nutrition education lesson plans, or assistance with a special nutrition talk for parents, or to refer a child for help with a nutritional problem you have identified. (You may contact the Office of Nutrition, Massachusetts Department of Public Health, for assistance; the number is (617) 727-9283.)

The major food assistance programs are administered by the U.S. Department of Agriculture's Food and Nutrition Service together with state governments and local agencies.

In Massachusetts, the Department of Education has responsibility for food programs serving children in schools, day care centers, and summer recreation centers. The Department of Public Welfare has responsibility for the Food Stamp program and the Department of Public Health administers the Special Supplemental Food Program for Women, Infants and Children (WIC).

All federal and state food assistance programs are available to all eligible persons without regard to race, color, national origin, sex, age, or disability.

■ CHILD CARE FOOD PROGRAM (CCFP)

The Child Care Food Program is the most common food program in which day care centers participate. This program helps day care centers and child care institutions serve nutritious meals and snacks to preschool and school-aged children. To participate, centers and institutions must be licensed or approved by the Office for Children or local Boards of Health to provide child care services in Massachusetts.

All public and private non-profit licensed or approved non-residential day care services and all for-profit centers that receive Title XX funds (low-income assistance from U.S. Department of Health and Human Services) for at least 25 percent of the children they serve are eligible to participate. This program is available to all children twelve years of age and under, to all migrant children fifteen and under, and to all handicapped children in participating institutions and facilities where the majority of the children are eighteen years of age or under. Day care centers and school-age child care centers can participate either independently or through a sponsoring organization that accepts administrative and financial responsibility for the program. Family day care homes can participate through a sponsoring organization.

Participating facilities and institutions get cash assistance, USDA-donated foods, and technical guidance. In day care centers, the amount of cash assistance varies according to the family size and income of children served. In family day care homes, the amount of cash assistance is based on a food service payment rate.

In order to become enrolled in the Child Care Food Program, you must write a letter of request to CCFP, Department of Education, Bureau of Nutrition Education and School Food Service, 1385 Hancock Street, Quincy, MA 02169. You will receive an application, regulations, and training materials. For further information, see Appendix 18. ☎ You can also call the Massachusetts Child Care Food Program Coordinator at (617) 770-7260.

■ FOOD DISTRIBUTION PROGRAM

Through the Food Distribution Program, USDA purchases surplus foods from U.S. markets and distributes them to state agencies for use by eligible local agencies. The foods go to schools and institutions participating in the child nutrition programs (school lunch, school breakfast, summer feeding, and after-school programs), to nutrition programs for the elderly, to needy families on Indian reservations, and to hospitals and prisons.

Day care centers and family day care homes licensed by the Office for Children are eligible to participate in the food distribution program. To enroll, a day care center must request an application from:

Bureau of Nutrition Education and School Food Services
Special Food Service Program
1385 Hancock Street
Quincy, MA 02169

☎ If approved, they can elect to receive commodities or cash. Programs already enrolled in CCFP automatically receive an application for the food distribution program. For further information, call (617) 770-7248.

■ FOOD STAMP PROGRAM

The Food Stamp Program helps needy households purchase the foods they need for good health. Participating families get coupons, free of charge, which they exchange for food at authorized stores.

☎ People can apply for food stamps at their local food stamp office or call toll free 1-800-882-1223 for information.

■ SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

The Special Supplemental Food Program for Women, Infants, and Children is commonly known as WIC. WIC is a federally funded food and nutrition education program for pregnant, postpartum, and breastfeeding women, infants, and children under age five who are low income and at nutritional risk. WIC is operated by local health clinics and other authorized health facilities. In Massachusetts, approximately 65,000 women, infants, and children are enrolled in the WIC program.

Nutritionists counsel WIC participants concerning specific dietary needs, eating patterns, and use of WIC foods (milk, cheese, eggs, 100 percent fruit juice, iron-fortified cereals, peanut butter, dried peas and beans, infant formula, and infant cereal). WIC's goal is to promote beneficial changes in eating, food preparation, and shopping habits that will positively affect health.

WIC programs provide supplemental foods in one of three ways: they obtain foods from local firms and distribute them directly; they arrange for home delivery; or they give mothers vouchers to exchange for specified items at authorized grocery stores. Most WIC programs in Massachusetts give vouchers to participants.

☎ *For information call 1-800-WIC-1007.*

■ NUTRITION EDUCATION AND TRAINING PROGRAM (NETP)

Under the federal Nutrition Education and Training Program (NETP), funds are granted to the States for the dissemination of nutrition information to children, and for inservice training of teachers and food service personnel. The program is for all children in public and private schools and in residential and nonresidential child care institutions.

The NETP encourages community involvement in nutrition education and contributes to general consumer awareness concerning the relationship between proper nutrition and health. The program's major goals are:

- To encourage good eating habits and teach children the relationship between food and health
- To train food service personnel in nutrition and food service management
- To encourage use of the cafeteria or dining area as an environment for learning about food and nutrition
- To instruct educators in nutrition education
- To develop appropriate educational materials and curricula

Child care programs can apply to NETP for small grants to start nutrition education programs. Copies of previously funded nutrition projects are also available for loan; some of these may be appropriate for day care centers. For further information, call the NETP Coordinator, Bureau of Nutrition and School Food Services, (617) 770-7254.

■ EMERGENCY FEEDING AGENCIES

The Hunger Hotline

The Hunger Hotline is a comprehensive information, referral and advocacy center for food and hunger issues, connecting community resources to emergency food providers throughout Greater Boston. The Hunger Hotline works with over 270 agencies which are serving over 30,000 individuals a month. The Hunger Hotline works to make food accessible to needy people.

Project Bread Hunger Hotline
14 Beacon Street
Room 608
Boston, MA 02108
523-7010

Food Banks

Food banks are nonprofit corporations that serve as clearinghouses for soliciting, receiving, storing and redistributing surplus or salvage foods from growers, processors, markets and restaurants to other nonprofit groups. Food banks offer food to nonprofit organizations feeding those in need at food pantries, soup kitchens, day care centers, shelters, or detox facilities. The food is obtained at a low cost to the agencies – a copayment, usually 10 cents a pound, which covers the operating cost of the food bank. *Food banks do not provide food to individuals.* There are three food banks in Massachusetts:

1. Boston Food Bank
   1693 Columbus Avenue
   Boston, MA 02119
   (617) 427-5831

2. Western Massachusetts Food Bank
   47 East Street
   Hadley, MA 01035
   (413) 586-6067

3. Worcester County Food Bank
   15 Ripley Street
   Worcester, MA 01610
   (617) 798-0191

Food Pantries

There are 120 food pantries in the City of Boston and 145 pantries in the suburban Boston area. These pantries, which provide families with a three-day supply of nonperishable groceries, are located in churches and social service agencies and some in the homes of families who use and operate them. In the Boston area, the Hunger Hotline can refer you to food pantries in your community. Outside the Boston area, contact the nearest food bank for information on food pantries.

Soup Kitchens

There are 27 soup kitchens in the City of Boston and 25 soup kitchens in the suburban Boston area. Soup kitchens offer not only meals but respite from the weather and isolation. These meal programs are open to all in need. Church-affiliated nonprofit organizations operate the majority of the meal programs in the city. In the Boston area, the Hunger Hotline can refer you to soup kitchens in your community. Outside the Boston area, contact the nearest food bank for information on soup kitchens.

■ ADDITIONAL RESOURCES

Expanded Food and Nutrition Education Program (EFNEP)

EFNEP serves low-income families with children. It is regarded by many as the nutrition education component of the Food Stamp Program. Nutrition aides under the direction of a registered dietitian or nutritionist visit homes and provide one-to-one education on general and specific nutrition problems. The aides teach food budgeting, purchasing, and preparation. A list of EFNEP offices in Massachusetts is included in Appendix 19.

Massachusetts Nutrition Resource Center (MNRC) - Nutrition Hotline

The Massachusetts Nutrition Resource Center (MNRC) works to promote healthy lifestyles through improved nutrition awareness. Professional nutritionists provide answers to questions about food, nutrition, and health; referrals to nutrition services throughout the state; and a wide variety of free nutrition materials and packets, including "Nutrition for Young Children," "How to Lose Weight," and "Diet for Today's Woman." MNRC is a service of the Center for Health Promotion and Environmental Disease Prevention of the Massachusetts Department of Public Health and the Frances Stern Nutrition Center of New England Medical Center Hospitals.

☎ *Call the Nutrition Hotline toll free at 1-800-322-7203*
Weekdays 9 A.M. – 3:15 P.M.

Or write:

Massachusetts Nutrition Resource Center
150 Tremont Street
Boston, MA 02111

Boston Urban Gardeners (BUG)

BUG assists families of low- and moderate-income neighborhoods to develop community vegetable gardens. Since 1976, over 130 community gardens have been developed where more than 5,500 families are producing food for themselves.

BUG
20 Park Plaza
Room 831
☎ Boston, MA 02116
(617) 423-7497

References

Goodwin, M.T. and Pollen, G. Creative Food Experiences for Children. Washington, D.C.: Center for Service in the Public Interest, 1980.

Howard, R.B. and Herbold, N.H. Nutrition in Clinical Care. 2nd Edition. New York: McGraw-Hill Book Company, 1982. (Chapters 25 & 26.)

Howard, R.B. and Winter, H.S. Nutrition and Feeding of Infants and Toddlers. Boston: Little Brown and Company, 1984.

Ivens, B.J. and Weil, W.B. "Teddy Bears and Bean Sprouts--The Infant and Vegetarian Nutrition." Fremont, MI: Gerber Products Co., 1984.

Massachusetts Department of Public Health. Infant Feeding Policy. Boston, June 1984.

Massachusetts Nutrition Resource Center. "What If Your Child....." Boston: Massachusetts Nutrition Resource Center, 1984.

Satter, F. Child of Mine - Feeding with Love and Good Sense. Bull Publishing Company, 1983.

State of Washington, Department of Social and Health Services, Nutrition Education Training Program. Food For The Preschooler. Volume I, II, III. 1981.

U.S. Department of Agriculture, Food and Nutrition Service. A Planning Guide for Food Service in Child Care Centers. FNS-64. Washington, D.C.: Government Printing Office, 1985.

U.S. Department of Agriculture and U.S. Department of Health and Human Services. Nutrition and Your Health: Dietary Guidelines for Americans. 2nd Edition. Home and Garden Bulletin No. 232. Washington, D.C.: Government Printing Office, 1985.

Introduction

Every child requires good preventive health care, including regular health assessments as described in Chapters 9 and 11. For a group of children who have special health issues, this type of care alone is not enough. Some children, who have been diagnosed with a health or developmental problem or who are at risk of developing particular problems, demand a special level of health care. Typically, in these cases, the health team includes a group of health specialists (such as physical therapists, occupational therapists, speech and language pathologists, neurologists, orthopedists, etc.); developmental specialists, including educators; and mental health professionals. Please refer to Appendix 7 for a glossary of commonly used specialists.

As described earlier, health impacts on every area of children's development. Children with special needs may have mild, moderate, or severe conditions. These conditions may include health impairments, physical disabilities, developmental disabilities, emotional disturbance, speech and language impairments, or sensory (vision, hearing) problems. Children who are abused and/or neglected may have a variety of emotional and/or physical needs. Children who have been lead poisoned may have mild to serious health problems and are at risk for developmental and educational difficulties. Chronic illness, in addition to creating health concerns, can affect the child's total development as well.

While this section of Health in Day Care will not discuss every special health issue, it will address some of the most common (though still rare) conditions you may find among your children at day care. Specifically, this section includes these chapters:

Chapter 13: Services for Children with Special Needs
Chapter 14: Child Abuse and Neglect
Chapter 15: Lead Poisoning
Chapter 16: Chronic Illness

Throughout this section, these major concepts are highlighted:

1. Children with special health needs need a team approach of health and mental health professionals and specialists, day care staff, and parents to meet their needs.

2. Most children with mild and moderate special health needs can be served in day care programs with proper prior planning.

3. Day care staff, along with other members of the team including parents, need to observe carefully for signs and symptoms of special health needs.

4. In Massachusetts, a wide variety of community resources at the state, regional, and local levels are available to assist day care programs and families.

5. Some conditions, such as lead poisoning and abuse and neglect, are preventable. Some conditions, such as chronic health problems or physical disabilities, are not preventable. *All* these special health issues require appropriate intervention, regular monitoring, and on-going care.

6. Whenever possible, children with special health needs should *not* be excluded from activities. Rather, you should give extra help, change your expectations, or modify the materials or activity.

13 Services for Children with Special Needs

Introduction

For many young children with special needs, the community day care center or nursery school is the best place to be enrolled. Children with a wide range of problems or disabilities -- those with speech and language problems; problems getting along with other children; chronic illnesses; family difficulties; abusive or neglectful parents; and with developmental delays or physical impairments -- can benefit from being in group situations with non-handicapped children. The lives of other children and staff can also be greatly enriched by including special needs children in "regular" early childhood programs.

To help make the experience a positive one, several steps should be taken:

1. Make sure that the child's problem or condition has been evaluated by competent, experienced professionals, and get detailed information from parents. If the child has a particular disability (e.g., mental retardation, cerebral palsy), contact the voluntary agency for that condition (for example, the Association for Retarded Citizens) for general information.

2. Share the information you receive with the other staff members, and provide ongoing opportunities for them to ask questions and express their concerns about enrolling or maintaining the child in that program. Include staff in the decision-making process.

3. Think ahead as you plan activities for the child's group. Which activities will allow the child to excel, which will encourage cooperation between this child and the others, which will be difficult for the child to enter?

4. Consider the range of "extra" services the early childhood program will need to provide. What special supports or services for the child and family are necessary? Are those services available without straining the program's resources?

5. Become familiar with people and agencies in the community who can help you make enrollment decisions, plan individually-tailored programs, if necessary, or provide consultation to you. Know where you can refer the family if additional help is required, and be aware of when these referrals should be made.

6. Keep the child's parents involved in all aspects of this integration process. Ask for their input and suggestions.

7. Prepare the other children for the special needs of this child, if that is appropriate. Encourage the other children to ask questions of staff members and discuss their feelings about the child in a constructive way. Introduce disability awareness materials into the curriculum.

Some children with special needs will require extensive individual program planning and extra services. Others will need staff to help them for limited times (e.g., when a parent is hospitalized) or for some specific activities. Whatever the "special need," day care center staff must remain attentive to reactions of the child, his/her family, the other children in the program, and staff members; and they must be flexible in planning activities. Each program also needs to be realistic about which children it can safely and appropriately serve and which it cannot; children should be considered on a case-by-case basis.

Several other chapters may also be helpful. For example, Chapter 6 presents safety issues for you to consider with a particular special-needs child in mind. Chapter 8 offers emergency-related advice which may have special importance for a program with a handicapped child. Chapter 14 presents information on a special needs group -- abused or neglected children, and Chapter 16 describes chronic health conditions which you may encounter. This chapter describes resources which are available in most communities, and which can be helpful to you as you make enrollment and programming decisions for children with special needs.

This chapter includes the following topics:

- Resources for Infants and Toddlers
- Resources for Preschoolers Three to Six Years
- Resources for All Ages

Resources for Infants and Toddlers

EARLY INTERVENTION PROGRAM CONSULTATION

There are 41 early intervention programs, funded by the Massachusetts Department of Public Health and located throughout Massachusetts (see Appendix 3). These programs provide intensive therapeutic intervention for local children from birth to three years, who are handicapped or "at-risk" of becoming handicapped. In addition to this direct service, early intervention staff are encouraged by DPH to provide consultation to local preschool programs serving infants and toddlers. The staff usually include infant specialists, physical therapists, occupational therapists, developmental educators, social workers, speech and language therapists, psychologists, and pediatric nurses. They can help in individual child assessment, program planning, adaptive equipment, suggestions for resources, and designing parent groups.

HIGH-RISK INFANT COMMUNITY-BASED SUPPORT PROGRAMS

The Massachusetts Department of Public Health funds thirteen home-based programs for families with infants born at-risk for developmental delay. (See Appendix 3.) This at-risk group includes babies who are born prematurely, those with congenital anomalies (birth defects), and/or those who have required care in a neonatal intensive care unit. Adolescent mothers and mothers with substance-abuse problems, or with physical or psychological illnesses are eligible for these home-based support services as well. The programs primarily are administered by Visiting Nurses Associations (VNAs).

Program staff assess social, emotional, medical, and psychological needs and provide intervention and/or referral as necessary. There is an emphasis on health education and on establishing linkages with primary care providers.

Resources for 3-6 Year Olds

SPECIAL EDUCATION

The Massachusetts Special Education Law (Chapter 766) guarantees every child regardless of handicap or special need an appropriate, publicly funded education. The law includes three- and four-year-olds with *substantial disability* under its provisions. Some children currently enrolled in private day care centers may qualify for publicly funded education under this law. Each community's Local Education Agency (LEA or school system) is responsible for the eligible preschoolers in its district, including conducting evaluations for three- and four-year-olds referred by parents (or through others with parental permission).

The LEA is required to provide a timely assessment of any referred three- or four-year-old child to determine whether or not the child has substantial disability. If so, the LEA, together with the child's parents, recommends an educational plan and placement for that child which fulfills his/her educational needs. Preschool programs should urge parents to have their children evaluated if there is serious concern about the child's development. While the child might well remain in the original preschool, it is best to have an assessment and plan the most appropriate program.

If the child is determined to need services, the law requires children to be served in the least restrictive environment -- that is, with non-handicapped children, if possible. One option open to LEA's for a child found to be substantially disabled is to pay tuition in a private preschool. This type of placement is not often made, but if you are interested in offering such services, you may want to contact public schools in your service area. Day care programs receiving 766 funding must meet specific OFC standards as well.

The Department of Education has six Regional Education Centers throughout the state. (See Appendix 10 for a listing.) At each Center, there is an Early Childhood Specialist who focuses on school services for young children with special needs. These individuals are available for consultation and technical assistance as well as training opportunities. Resources for children with special needs, such as videotapes, puppets, screening tools, and books, are available for loan. (See Resources Appendix 24 for more information.) You can also contact the statewide Coordinator for Early Childhood Education at the central Department of Education office (1385 Hancock Street, Quincy MA 02169; 617/770-7479).

INTEGRATED PRESCHOOLS

The Massachusetts Department of Public Health currently funds four Integrated Preschool Programs (see Appendix 3) which offer model early childhood programming for children with and without handicapping conditions. In integrated preschool programs, occupational, physical, and speech therapy are incorporated in a school setting that brings together disabled and able-bodied students between the ages of three and six. There is no charge to families of disabled children. Referrals may be made directly to the program or through the local education agency. These programs also have a community outreach component, providing training for professionals and other community members.

■ OUTREACH AND TRAINING TEAMS

The Massachusetts Department of Public Health currently funds three Outreach and Training Teams (see Appendix 3). The Teams develop training to help providers maintain children with disabilities in the least restrictive environment, whether at home or elsewhere in the community. Activities include parent advocacy and effectiveness training, and consultation to family and group day care, preschools, public schools, and educational collaboratives. The Teams provide consultation on individual children, introduce non-handicapped children to disabilities, and suggest ways to integrate disabled children into least restrictive settings.

■ HEAD START

Head Start programs are required to serve handicapped children; at least ten percent of each program's total enrollment must be handicapped. As a result, each individual Head Start program has experience serving children with special needs and should be seen as a community resource for other preschool programs. Project Head Start also has published a series of booklets entitled Mainstreaming Preschoolers (1978), which is a valuable reference for all day care providers.

Resources for All Ages

■ PRESCHOOL ENRICHMENT TEAM

The Preschool Enrichment Team (P.E.T.) is an interdisciplinary team of health consultants serving nursery schools and day care centers in the Holyoke-Springfield area. Team members provide preventive health screenings and diagnostic assessments of children; training and technical assistance through workshops and on-site visits for teachers; and support and education for parents through written materials and public workshops (see Appendix 3). Information on resource materials available from P.E.T. is provided in Appendix 24.

■ DEPARTMENT OF MENTAL HEALTH (DMH): LOCAL AREA OFFICES

The Massachusetts Department of Mental Health operates area or neighborhood offices in over 40 locations throughout the state. Within each area office, there is a child mental health consultant who is an expert in child psychology, especially emotional and social development. This person can be a valuable resource to day care centers. Depending on other demands from the area office, this child consultant can provide the following:

- consultation on mental health issues, such as helping a child handle an upcoming divorce;

- supervision of staff members working with a child identified as having social-emotional difficulties;

- observation and assessment of children whose behavior or development concern the staff;

- referral for therapy or other services for children and/or families.

The address and phone number of the nearest DMH area office can be found in your phone book under the "Massachusetts, Commonwealth of" listings.

DEPARTMENT OF SOCIAL SERVICES (DSS): LOCAL AREA OFFICE

The Massachusetts Department of Social Services is responsible for providing a wide variety of services to children and families, including foster care and adoption, homemaker services, parent and child counseling. DSS is the state's child protection agency and also the major public contractor for day care services. Like the Department of Mental Health, DSS is organized into area offices which serve particular neighborhoods or geographical areas. (See Appendix 20 for a listing.)

All day care staff should be familiar with the local DSS office, since they are "mandated reporters" of suspected child abuse or neglect (See Chapter 14). In addition to responding to child abuse or neglect reports, the DSS office can provide the following services to day care centers:

- consultation on how to deal with a child placed in that center as a "protective" case (supportive services slot);

- training staff in identifying signs of abuse or neglect;

- providing an opportunity for staff to discuss their feelings about a family under investigation.

OFFICE FOR CHILDREN: AREA OFFICES AND COUNCILS FOR CHILDREN

The Office for Children (OFC) is the day care licensing agency in Massachusetts. OFC also coordinates local groups called Councils for Children, which are made up of area child and family professionals, parents, and other concerned citizens who monitor local services for children and act as advocates for children's services.

Day care center staff and family day care providers should consider becoming involved with the Councils so that child care issues and concerns are strongly represented. The Councils also provide on-the-job training in topics related to children's services.

Help for Children, another OFC program, is a statewide information and referral network which helps find or match services for individual children who seem to "fall through the cracks." This may be particularly relevant for preschool children with special needs enrolled in family day care homes or day care centers, who need developmental assessments, referrals for child or family therapy, etc. Help for Children staff can serve as advocates for both families and other providers in obtaining services from the human services and educational systems. Appendix 21 lists the area and regional Office for Children locations and which cities and towns they serve.

The Office for Children is also the agency which funds *Child Care Resource and Referral* agencies (CCRR's). These programs provide information, education, and referral services for parents, providers, and potential providers. They coordinate existing child care resources, develop new resources, and make day care visible and accessible in each community. The CCRR agencies form the keystone of the Governor's Day Care Initiative whose goal is to integrate public and private efforts to increase the availability of affordable, quality day care throughout the state.

The Office for Children is presently funding twelve Child Care Resource and Referral agencies. As of 1987, there is a statewide network of agencies which cover every city and town. For information about a CCRR services in your community, contact your local CCRR. See Appendix 22 for a listing of current CCRR's and service areas.

■ VOLUNTARY AGENCIES

Private groups and agencies have been organized to inform the public about many disabilities and help children with handicapping conditions and their families. For example, Associations for Retarded Citizens (ARC's), and United Cerebral Palsy (UCP) organize a variety of support and education programs for parents and families of a child with these disabilities.

If your day care center has enrolled a child with special needs, contact the voluntary agency representing that condition for information for the center, the child and the family. Many of these agencies belong to the Federation for Children with Special Needs, an umbrella agency in Massachusetts that can help you with special needs children. They can be reached at 32 Stuart St., Boston, MA 02111, 617-482-2915.

14 Child Abuse and Neglect

Introduction

This chapter will provide an overview of child abuse and neglect -- two very important health problems of preschool children. Most of the material in this chapter is from materials published by the Massachusetts Department of Social Services (DSS), which is responsible for investigating cases of abuse and neglect. This chapter will answer basic questions and list resources for further assistance; we urge you to seek other resources as needed.

The Department of Social Services depends on reports from professionals like yourself and other concerned people to learn about children who may need protection and families who might benefit from DSS services.

Chapter 119, section 51A of Massachusetts General Laws, mandates the Department of Social Services to receive reports of possible abuse or neglect. The Department provides a full range of protective services for children, plus a network of family support services such as counseling, day care, and parent aides.

Chapter 119, section 51A of Massachusetts General Laws, also defines your responsibilities as a *mandated reporter*. All references to Massachusetts law in this chapter are citations from Chapter 119, section 51A.

Fifty-five percent of reports received by DSS are from professionals like yourself -- mandated reporters; almost 90 percent of these reports are screened for investigation. Reports received by DSS during Fiscal Year 1983 involved a total of 32,640 children, or approximately one out of every sixty children in the state.

Child abuse happens in each of our communities -- urban, suburban, and rural -- and to families at all income levels.

It happens when parents:

- are under stress
- are isolated, without support
- feel that their failures outnumber their successes
- keep their frustrations inside until they finally boil over.

Many of the causes of child abuse can also be traced to general problems of society such as:

- economic "hard" times
- unemployment
- the loss of a supportive, community feeling in our neighborhoods
- the acceptance of violence as a way of dealing with problems.

Questions and Answers About the Law

■ WHAT ARE CHILD ABUSE AND CHILD NEGLECT?

According to Massachusetts law and Department of Social Services regulations (110 CMR 4.00); these terms are defined below.

Abuse

- The non-accidental commission of any act by a caretaker which causes or creates a substantial risk of harm or threat of harm to a child's well-being
- The commission of a sex offense against a child as defined by the criminal laws of the Commonwealth.

Neglect

- Failure by a caretaker, either deliberately or through negligence, to take actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision or other essential care
- Physical dependence of a child upon an addictive drug at birth.

Serious physical injury

- Any non-trivial injury, death, malnutrition, and failure to thrive.

Serious emotional injury

- An extreme emotional condition such as a severe state of anxiety, depression, or withdrawal.

Sexual abuse

- Exploitation of a child for the sexual pleasure of the adult (i.e., rape, incest, fondling of private areas, exhibitionism, photographing for pornography).

Please refer to Figures 30, 31, 32, and 33 which list indicators of child neglect, physical and behavioral indicators of child abuse, and indicators of sexual abuse.

■ WHO IS A MANDATED REPORTER?

All administrators of day care centers, licensed family day care providers, and their employees (teachers, aides, assistants) are mandated reporters.

Other mandated reporters include: physicians, medical interns, hospital personnel, medical examiners, psychologists, emergency medical technicians, dentists, nurses, chiropractors, podiatrists, osteopaths, public or private school teachers, educational administrators, guidance or family counselors, probation officers, social workers, foster parents, fire fighters, and police officers.

■ HOW DO I DECIDE WHETHER OR NOT TO REPORT?

If you are a mandated reporter you *MUST* file a report if you have reasonable cause to believe that:

- A child is suffering from serious physical or emotional injury resulting from abuse inflicted upon her/him, including sexual abuse
- A child is suffering from neglect, including malnutrition
- A child is physically dependent upon an addictive drug at birth.

"Reasonable cause" means that, after examining all the facts in a particular situation, most people with similar training and experience would also suspect abuse. This is a "reasonable person" standard commonly used in the law. It really is saying you should use your professional knowledge of the child to make an informed decision.

Figure 30

Indicators of Child Neglect ✔

LACK OF SUPERVISION
- Very young children left unattended
- Children left in the care of other children too young to protect them
- Children inadequately supervised for long periods of time or when engaged in dangerous activities

LACK OF ADEQUATE CLOTHING AND GOOD HYGIENE
- Children dressed inadequately for the weather
- Persistent skin disorders resulting from improper hygiene
- Children chronically dirty and unbathed

LACK OF MEDICAL OR DENTAL CARE
- Children whose needs for medical or dental care or medication and health aids are not met

LACK OF ADEQUATE EDUCATION
- Children who are chronically absent from school

LACK OF ADEQUATE NUTRITION
- Children lacking sufficient quantity or quality of food
- Children consistently complaining of hunger or rummaging for food
- Children suffering severe developmental lags

LACK OF ADEQUATE SHELTER
- Structurally unsafe housing or exposed wiring
- Inadequate heating
- Unsanitary housing conditions

IN IDENTIFYING NEGLECT, BE SENSITIVE TO
- Different cultural expectations and values
- Different child-rearing practices

Neglect is not necessarily related to poverty; it reflects a breakdown in household management, as well as a breakdown of concern for and caretaking of the child.

Figure 31

Physical Indicators of Child Abuse

The following are often seen in cases of abuse or neglect. They should be considered in light of explanations provided, medical history (especially if inconsistent), and the developmental abilities of the child to engage in the activities said to cause the injury.

BRUISES AND WELTS

- Bruises on any infant, especially bruises on the face
- Bruises on the back side of a child's body
- Bruises in unusual patterns that might be made by an instrument (e.g., belt buckle or strap) or human bite marks
- Clustered bruises that might indicate repeated contact with a hand or object
- Bruises in various stages of healing

BURNS

- Immersion burns indicating dunking in a hot liquid ("sock" or "glove" burns on the arms or legs or "doughnut" shaped burns of the buttocks and genitalia)
- Cigarette burns
- Rope burns
- Dry burns indicating that a child has been forced to sit upon a hot surface or has had a hot instrument applied to the skin

CUTS, TEARS OR SCRAPES

- Cuts of the lip, eye, or any portion of an infant's face
- Any cut or scrape on external genitalia

HEAD INJURIES

- Absence of hair or bleeding beneath the scalp due to hair pulling
- Black eyes
- Bruised, bloody, swollen eyes
- Swollen mouth or jaw
- Loosened or missing teeth

If injuries look more serious, children probably should be taken to a physician or hospital. Physicians may diagnose the following injuries.

BONE INJURIES

- Rib fractures
- Fracture of the jaw, breastbone, shoulder blades
- Skull injuries
- Spinal injuries
- Repeated injuries to the same place
- Injuries caused by twisting or pulling that a doctor may see on X-rays.

HEAD INJURIES

- Bleeding beneath the outer covering of the brain (due to shaking or hitting)
- Bleeding behind the eye, or detached retina (due to shaking)

INJURIES TO STOMACH AREA

- Rupture or bruising of internal organs
- Serious abdominal pain or injury
- Shock

Figure 32
Behavioral Indicators of Child Abuse ✓

Children who are abused physically or emotionally may have certain types of behavior. Many of these behaviors are common to all children at one time or another, but when they are present often enough and strongly enough to describe a child's overall manner, they may indicate abuse.

Children learn specific coping skills to deal with the world at large. As they struggle to get their needs met in a disturbed, stressful household, they may learn to deny or exaggerate parts of themselves. The behavior of abused children may be:

- Overly compliant, passive, undemanding, shy, withdrawn, affectionless, listless, detached
- Nervous, hyperactive, aggressive, disruptive, destructive, irritable
- Unusually fearful of adults
- Fearful of going home or being left in someone's care

The child may have:

- Repeated nightmares
- Phobias, fear of darkness or bathrooms
- Chronic complaints such as stomachaches

Figure 33
Indicators of Sexual Abuse ✓

PHYSICAL INDICATORS

- Difficulty in walking or sitting
- Torn, stained or bloody underclothing
- Complaints of pain, itching, or swelling in genital area
- Pain when urinating
- Bruises or bleeding in external genitalia, vaginal or anal areas, mouth or throat
- Vaginal discharge
- Venereal disease or vaginal infections

BEHAVIORAL INDICATORS

- Unwilling to have clothes changed or to be assisted with toileting
- Holds self, wants to be changed although not wet
- Unwilling to participate in physical activities
- Extreme changes in behavior such as loss of appetite
- Withdrawn or infantile behaviors; may go back to earlier behaviors (such as bedwetting, thumb sucking)
- Extremely aggressive or disruptive behavior
- Unusual interest in or knowledge of sexual matters; expressing affection in ways inappropriate for a child of that age
- Poor peer relationships
- Fear of a person or a strong dislike of being left somewhere or with someone
- Child reports sexual assault by caretaker

If you have further questions about whether or not to make a report, you should feel free to call your local office of the Department of Social Services to discuss your questions. You should also feel free to discuss your questions with other professionals.

■ WHAT IS THE DISTRICT ATTORNEY REPORTING LAW?

As of 1983, the Department of Social Services is required to notify the District Attorney's office in writing if a child has:

- Died
- Been raped
- Been sexually exploited
- Received brain damage, loss or substantial impairment of a bodily function or organ, or substantial disfigurement
- Been repeatedly abused by a family member.

■ SHOULD I TELL THE PARENT BEFORE I REPORT?

This is probably the most difficult decision you will have to make.

Of course, if a child is in imminent danger and you believe the parent might disappear with the child, call the police immediately and do not tell the parent. More frequently, however, you will be faced with a situation where you know and care about the parent, and the child is not in imminent danger. Telling the parent will frequently bring out hostility and anger, which may spur the parent to remove the child from your care. On the other hand, if you fail to inform parents, they may feel betrayed or deceived, and your relationship may be destroyed. *As a general rule, it is probably better to inform the parent of your decision to make a report.*

You might start by explaining that, as a day-care worker, you are a mandated reporter, *required by law* to report instances of known or suspected child abuse. The law does *not* give you a choice.

Filing a report can be described as making a referral to a social services agency to request help and supportive services for the child and family. You might explain that the reporting process does not always go smoothly, but that you care very much about the family and will do everything you can to see that the family receives help.

The intent of the law is to maintain family unity, and social workers will remove the child from the home only as a last resort. If you believe that you can offer further help and support, let the parent know that you want the child to remain in your care, that you want to continue your relationship with the family, and that you believe this is a problem which *can* be solved. Parents need to know that they are not inherently "bad" parents, that they can be helped, and that their problem is not unique.

■ TO WHOM MUST I REPORT?

Once you have decided a report must be made, you are required to call the local office of the Department of Social Services. (See Figure 34.) If you are unsure of which office to call or need the telephone number, call the DSS Central Office at (617) 727-0900, Ext. 292. Within 48 hours your telephone report must be followed up by a written report. You may get forms for submitting your written report from the Department of Social Services. After business hours and on weekends and holidays, you can call the statewide *Child at Risk Hotline at 1-800-792-5200.* However, if a child is in immediate physical danger, call your local police.

■ WHAT INFORMATION MUST A REPORT CONTAIN?

A report should provide as much detail as possible. The more detailed the report, the more appropriate the Department's response will be to the particular situation. Please refer to Figure 35 for specific information needed for the report.

■ WHAT IF THE REPORT TURNS OUT TO BE UNTRUE?

All mandated reporters are *immune by law* from civil or criminal liability for filing a report, even if abuse is not confirmed by the investigator (Massachusetts General Laws, Ch. 119, s. 51A). This means that even if someone sues you for reporting, the court will dismiss the case when it is revealed that you are a mandated reporter.

■ WHAT IF I FAIL TO FILE A REPORT?

A mandated reporter who fails to report known or suspected instances of child abuse may be punished by a fine of up to $1,000. Failure to report might also result in civil liability if a child is harmed after the mandated reporter learns of abuse and fails to report it. The duty to report is an *individual* duty. Even if your boss or coworkers discourage you or try to prevent you from reporting, if you know or have reason to believe abuse has occurred, you must file a report.

When two or more coworkers know of child abuse, only one report must be filed. Large day care facilities should adopt special procedures to be followed for child abuse reporting. This will avoid confusion and ensure that the process goes smoothly.

Figure 34

Where to Report Abuse or Neglect

REPORTING CHILD ABUSE AND NEGLECT BETWEEN 9 A.M. AND 5 P.M.

AREA DSS OFFICES

REGION I

1	Pittsfield	413-499-7370
2	Greenfield	413-774-5546
2A	Northampton	413-586-8480
3	Holyoke/Chicopee	413-536-4762
4	Springfield	413-781-0881
5	Westfield	413-562-9681

REGION II

6	Fitchburg	617-345-2101
7	Gardner	617-632-9104
8	Whitinsville	617-234-6213
9	Webster	617-949-0113
10	City of Worcester	617-791-1200

REGION III

11	Lowell	617-454-5255
12	Lawrence	617-689-2688
13	Haverhill	617-373-2310
14	Beverly/Gloucester	617-922-1719
15	Danvers/Salem	617-741-0018
16	Lynn	617-593-5755
16A	Chelsea	617-884-4077
17	Wakefield	617-246-0172
18	Malden, Medford & Everett	617-322-7125

REGION IV

19	Concord/Acton	617-263-8159
20	Arlington/Woburn	617-641-1780
21	Waltham	617-894-4865
22	Cambridge/Somerville	617-666-5670
23	Marlborough	617-481-2640
24	Framingham	617-872-8122
25	Newton	617-965-2607
26	Norwood	617-769-8780
27	Quincy	617-773-8920
28	Weymouth	617-331-6600

Figure 34 (cont.)

REGION V		
29	Attleboro	617-226-4554
30	Brockton	617-588-2281
31	Plymouth	617-585-6534
32	Taunton	617-822-7762
33	Fall River	617-675-1146
34	New Bedford	617-997-3362
35	Cape and Islands	1-800-352-0711
REGION VI		
36-40	City of Boston and Brookline	617-227-0010

WHAT HAPPPENS AFTER 5 P.M. AND ON WEEKENDS?

The Department of Social Services provides a 24-hour child abuse and neglect hotline. To report suspected possible abuse or neglect after 5 P.M. and on weekends, please call the hotline.

☎ *TWENTY-FOUR-HOUR HOTLINE*

1-800-792-5200 (All areas except Region II)

1-800-922-8169 (Region II)

Figure 35

Making a Report of Child Abuse or Neglect

When you telephone a DSS Protective Screening Unit to make a report of possible child abuse or neglect, you will be asked to give, to the fullest extent possible, the following information:

1. **The name(s), address, present whereabouts, date of birth or estimated age, and sex of the reported child(ren) and of any other children in the household.**
2. **The names, addresses, and telephone numbers of the child's parents or other persons responsible for the child's care.**
3. **The principal language spoken by the child and the child's caretaker.**
4. **Your name, address, telephone number, profession, and relationship to the child. (Non-mandated reporters may request anonymity.)**
5. **The full nature and extent of the child's injuries, abuse, or neglect.**
6. **Any indication of prior injuries, abuse, or neglect.**
7. **An assessment of the risk of further harm to the child, and if a risk exists, whether it is imminent.**
8. **If the above information was given to you by a third party, the identity of that person, unless anonymity is requested.**
9. **The circumstances under which you first became aware of the child's alleged injuries, abuse, or neglect.**
10. **The action taken, if any, to treat, shelter, or assist the child.**

Remember, mandated reporters must follow up a verbal report with a written report within 48 hours.

DO I HAVE A RIGHT TO KNOW WHAT HAPPENS AFTER I REPORT?

A mandated reporter has the right to know the results of the investigation and any social services which the Department intends to provide to the child or the family (M.G.L. Ch. 119, s. 51A). The Department of Social Services will mail you a letter containing this information. If the Department fails to notify you, you can and should contact them. If you believe the child is still in danger, tell the investigator and explain why.

WHAT IF A CHILD SHOWS UP WITH AN UNTREATED INJURY?

If a child is left in your care with an injury which requires immediate medical attention, you must take the child to a doctor or to an emergency room.

As a routine practice, every day care provider should keep careful records for every child, noting all injuries received while in your care, and any other injuries you may become aware of. Include a description of the injury, date, time, how it was received if known, any statements by parent or child, treatment given, etc. (See Figure 17 in Chapter 8 for a sample Injury Report form.)

MAY I DISCIPLINE CHILDREN IN MY CARE THE SAME WAY THEIR PARENTS DO?

NO. Massachusetts Office for Children regulations prohibit child care providers from using corporal (physical) punishment, or from interfering for punitive reasons with daily functions of living such as eating, sleeping, or toileting (see 102 CMR 7.00 *et seq.*)

Note that this standard is more stringent for day care providers than it is for parents, who are given greater leeway in administering "reasonable discipline."

If you know or suspect that a day care provider has violated these regulations, you should register a complaint with the licensing division of the Office for Children in your region or call their central office in Boston at (617) 727-8900.

WHAT IF I AM ACCUSED OF ABUSE?

If a complaint of child abuse is filed against you, the complaints will be investigated by the Department of Social Services. The investigator may want to talk to parents of the other children in your care and may ask for a list of current registrants. It is possible that if you are one of the people most knowledgeable about a child, you may become involved in a larger investigation, even if there has been no specific complaint against you. If the Department substantiates the report after investigation, the Department must report the matter to the Office for Children. The

Office will thereafter conduct a licensing investigation of your day care facility. The Department may also refer the matter to the District Attorney's Office for possible criminal investigation. If you believe you are a suspect, do not panic, but you should probably consult a lawyer about your rights.

WHAT IF A CHILD DIES UNEXPECTEDLY?

One of the most difficult situations to deal with is the actual death of a child while at the day care center. And one of the most frightening types of death is that of a sleeping, apparently healthy infant for no apparent reason. Sudden Infant Death Syndrome (SIDS), also known as "crib death," is a well-recognized event in the health care field, and is the major cause of death in infants after the first month of life (up to two deaths per 1,000 live births). We do not yet fully understand the causes of SIDS, but we do know that it is *not* predictable or preventable. It is not caused by suffocation, aspiration, or choking on vomitus. The infant does not struggle or make any noises to alert a caretaker. There is nothing you as a day care provider could have done to prevent the tragedy.

However, because of the obvious trauma that an unexpected death in a healthy baby can cause, day care providers have been accused of abuse or neglect in such circumstances. In the very unlikely event that an apparent SIDS death occurs in your program, you should be aware that there is a statewide SIDS program available to assist you as well as the parents. The program can provide an autopsy at no cost to the family in order to verify that there was no identifiable "cause" of death (e.g., disease or suffocation) and has trained nurses available throughout the state to provide counseling, information, and referral. If the need arises, you should contact the SIDS program immediately. Call (617) 424-5742; professional staff are available 24 hours a day.

Preventing Abuse in Day Care

HOW CAN I BE INVOLVED IN PREVENTION?

A sensitive, perceptive caregiver may note early warning signs of a potentially abusive or neglectful situation. This is, of course, the best time to act. Become aware of and let parents know about community agencies that provide needed support services such as respite care, counseling, temporary shelter, drug treatment, food stamps, etc. Share your knowledge of child development and child-rearing techniques with parents. Let them know if you recognize signs of stress in their children. Share your concerns with parents and help them share their concerns with you.

Early attention and intervention could save a child from harm and maintain a family's integrity. Child care is your business and intervention to prevent child abuse is your responsibility. Discuss ways to approach parents with other day care providers. Make it part of your job to get to know parents so as to build a trusting, sharing relationship with them.

A most important part of prevention is educating young children about their rights to say "No." Particularly in the area of child sexual abuse, children can be taught their rights to stop the abuse and the need to tell a trusted adult about the experience. There are many excellent curricula, books, films, etc. for preschool children on this topic. Please refer to the Resource Guide on Child Sexual Abuse (Appendix 23) for resources in your area who can help you develop a preventive education program for your center's needs.

■ SCREENING FOR ADULTS WHO MAY BE INAPPROPRIATE TO CARE FOR CHILDREN

In the hiring process for day care staff, you should seek information about the applicant's experience and qualifications relevant to the job opening. You should seek observations which can help in determining the reliability and skills of the applicant as well as identifying incidents or issues which raise concern about the safety of children in the applicant's care.

Many states, including Massachusetts, have implemented procedures that require a criminal offender records check on providers and certain child care workers.

It is important to realize that CORI checks are not a perfect solution, but rather a tool that can help make child care settings safe for children. When coupled with good employee screening practices, proper staff supervision, and regular observation by parents, CORI checks can provide one more safeguard for the Commonwealth's children.

There are several ways to learn about an individual including:

- An interview with the candidate
- A reference check with the most recent employer, particularly employment that is child care related, as well as others
- An observation of the candidate in the job for which s/he is applying, if possible
- A search for information from those who know the candidate, including past co-workers and parents

- A check with the Criminal Offender Records Index

- Supplementary checks

Many programs have a probationary (trial) period for new employees. During this time, you will have the chance to monitor the new staff member by observing and discussing his/her performance. Parents should be encouraged to drop in and visit the new employee as well.

A major consideration for every program serving children should be to protect those children from abuse and neglect. Every program has a responsibility to inform staff of appropriate federal, state, local, and program regulations regarding child abuse and neglect. Written policies should be provided to each staff member regarding:

- A code of conduct for staff relating to their behavior with children

- Policies on reporting suspected child abuse and neglect

- Policies on investigating staff or job applicants for child abuse and neglect

- Policies on hiring staff previously accused, indicted, and/or found guilty of child abuse and neglect.

The most important step that program managers can take to guard against child abuse and neglect is to ensure that there is adequate day-to-day supervision of all staff.

15 Childhood Lead Poisoning

Introduction

Lead poisoning is the damage caused by too much lead in the body. Even amounts too small to cause symptoms can interfere with a child's learning and behavior. Large amounts may cause serious damage to the brain, kidneys, nervous system, and red blood cells. Young children are at greatest risk for lead poisoning because of their natural curiosity and hand-to-mouth activity. They are exposed to many sources of lead in their normal environment and absorb a high proportion of the lead they are exposed to, especially if their diets lack adequate iron or calcium.

Lead poisoning may seriously affect a child's behavior and ability to learn. Several recent studies have indicated that lead-poisoned children perform less well on a number of developmental assessment tests and that disabilities are related to the child's blood-lead level, developmental stage, and duration of lead exposure.

Knowledge of lead poisoning should be an essential aspect of training for all early childhood educators. Day care centers should be sure that a child's medical history contains lead screening results. Even low-level lead exposure may affect how a child behaves and learns.

To reduce a child's risk of lead poisoning, day care providers should learn the sources, risk factors, and effects of lead on child development. Day care providers should promote protective environmental safety and nutritional measures, educate parents about the dangers of lead poisoning, and encourage them to have their children screened for lead poisoning regularly. In addition, children at risk and children identified as lead-poisoned should get any educational evaluation and services to which they are entitled.

This chapter focuses on the following topics:

- Sources of lead
- Lead screening
- Treatment and follow-up
- Environmental management
- Measures to protect children
- Massachusetts Childhood Lead Poisoning Prevention Program

Sources of Lead

Most lead poisoning results from swallowing lead paint chips or leaded dust. While most interior and exterior paints sold since the mid-1970's have not contained lead, most older Massachusetts homes and public buildings (approximately 80 percent) still have layers of lead-based paint. Children become lead-poisoned from eating, chewing, or sucking on lead-painted surfaces or items coated with lead dust. Typical sources include railings, window wells and sills, door sills, toys, furniture, and jewelry. Children touching things with sticky fingers are more likely to pick up the contaminated dust or material.

Soil is often overlooked as a source of lead. Soil is contaminated by paint which has weathered or been scraped or sanded off buildings. Lead can also accumulate in soil from the residue of auto exhaust from gasoline containing lead. Children playing outdoors who get dirt on their hands and then put their hands in their mouths can become lead poisoned. Lead is most highly concentrated in house dust and in soil within three feet of a building or in areas close to busy streets, parking lots, and driveways. Dust and fumes created by home renovation and sand blasting are also important lead sources. Adults working in lead-related jobs or crafts can also contribute to a child's exposure by bringing home lead dust on their clothes, hands, and hair.

Lead Screening

Most children who are lead-poisoned show no symptoms. Early symptoms such as head and stomachache, tiredness, fussiness, and poor appetite are vague and can be easily mistaken for a viral infection, teething, or stress. A blood test is the only way to find out if a child is lead-poisoned.

The blood screening test is a simple fingerstick which collects a small amount of blood. The Massachusetts Childhood Lead Poisoning Prevention Program recommends that all children between the ages of nine months and six years be tested yearly. Children between nine months and three years who live in high-risk areas should be tested every six months.

Because lead levels tend to rise in the summer, a screening test should be done during the warm weather months, May through October. Most doctors will screen children for lead. Many Boards of Health also provide screening tests, usually at no cost. DPH staff also can provide lead screening for children in day care centers.

The blood is analyzed for two substances. The first test performed is erythrocyte protoporphyrin or EP. EP is very sensitive to lead and rises quickly after a child has been exposed. EP is also a measurement of the amount of iron available to a child and, in some cases, the EP is elevated because the child is iron-deficient. If the EP is normal, the specimen is usually not tested for lead but, if the EP is elevated, a lead test is performed. If an elevated blood-lead level is found, children will be referred to their health care providers for follow-up.

Treatment and Follow-Up

The kind of treatment depends on the blood test results. Medical follow up may involve nutritional counselling, iron supplements, or chelation therapy - the use of chemicals to help the body get rid of lead.

If the lead screening test is elevated, the child must have a venous lead test (blood drawn from a vein in the arm). Screening tests can be contaminated by lead on the child's or blood drawer's hands. A venous test, usually drawn from the vein inside the elbow, is the only way to determine the child's actual lead level.

The child's health care provider will decide on treatment based on the venous lead test. At moderate levels of lead poisoning, the medical treatment may be limited to removing the source of lead and testing the child's blood frequently to ensure that s/he is no longer being exposed. Sometimes iron is prescribed, since lead interferes with the body's ability to manufacture healthy red blood cells.

At higher levels of lead poisoning, children may be treated with a chelating agent. Chelation, from the Greek word "claw," removes lead from the body and causes it to be passed through the kidneys. This treatment, which consists of daily injections either into a muscle or through the vein, can be done in a hospital or through a clinic. Most often the treatment lasts for five days. Children who have very high lead levels may require more than one course of treatment.

Following the diagnosis and treatment of lead poisoning, children must continue to have frequent blood-lead tests to determine if additional treatment is necessary or to detect evidence of re-exposure.

Lead-poisoned children should have careful developmental testing to identify learning or behavioral problems. Although the medical treatment for lead poisoning cannot reverse brain damage, an enriched environment may help children overcome or compensate for their disabilities.

Environmental Management

In Massachusettts, when a child is identified as lead-poisoned, his or her dwelling is inspected by a state or local health inspector. The law requires that all deteriorating paint and all accessible, chewable lead paint be removed from interior surfaces, common areas, and exterior surfaces. Each case is followed until the deleading is completed and the child's lead level is normal.

Deleading is very hazardous. The Department of Public Health recommends specific safety precautions which must be taken to prevent poisoning workers as well as the occupants. Steps must also be taken to prevent contaminating other parts of the building, children's play areas, and soil. No children or pregnant women should be present during deleading, renovation, or sandblasting. OFC regulations require that every group day care center in Massachusetts must be inspected and, if necessary, deleaded.

Measures to Protect Children

- Most important, comply fully and promptly with Office for Children and Public Health regulations regarding lead testing and removal in day care centers.
- Have soil tested. Contact your nearest agricultural extension service for information.
- Never let a child dig in contaminated soil.
- Remove or cover contaminated soil. (Pave it, sod it, or add mulch, gravel, or new top soil.)
- Plant bushes close to the house to discourage play there.
- Plan gardens and play areas away from painted structures and busy roads.

- Install a fence or bushes as a barrier between busy streets and play areas and gardens.

- Provide a diet rich in iron and calcium, low in fats.

The same measures recommended to control the spread of germs will help prevent lead dust build-up on hands or surfaces.

- Clean your own and a child's hands frequently, especially before preparing food or eating, after touching pets or shoes, gardening, playing in dirt, or crawling.

- Wet mop floors, window wells, and sills frequently with a high phosphate detergent (e.g., TSP).

- Provide clean teething toys to discourage chewing on railings, painted items, or paper products.

- Teach children to throw away any food that falls on the floor.

- Keep indoor toys inside and outdoor toys outside.

THE MASSACHUSETTS CHILDHOOD LEAD POISONING PREVENTION PROGRAM

The Childhood Lead Poisoning Prevention Program (CLPPP) provides laboratory analysis of blood and other samples, screening, environmental inspections, enforcement activities, and case management of children who have elevated blood-lead levels. Staff members are also available to provide education and training on all aspects of lead poisoning and its prevention as well as to train and assist agencies who would like to provide lead screening for their clients. CLPPP's central office is located in Jamaica Plain. It can be reached by calling 617-522-3700 or toll-free 1-800-532-9571. The program also has staff in the four regional health offices (see Appendix 3).

In conjunction with the Division of Family Services, CLPPP also funds several community-based lead-poisoning prevention projects which provide a wide range of services. If there is a project in your area, it may be able to offer services to your program. Projects should be contacted directly at the addresses or phones listed in Appendix 3.

References

Needleman, H.L., Gunnoe, C., Levinton, A., et al. "Deficits in Psychologic and Classroom Performance of Children with Elevated Dentyne Lead Levels." New England Journal of Medicine, (1979), 300: 689-695.

Preventive Lead in Young Children: A Statement by the Centers for Disease Control, January 1986. U.S. Department of Health and Human Services, Atlanta, GA.

Statement on Lead Poisoning, Pediatrics, (1987), 79: 457-465.

16

Chronic Health Conditions

Introduction

Almost every day care center or early childhood program has enrolled a number of children with ongoing health problems or medical conditions. For example, more than one of every ten preschool children has some type of allergy, making allergies the most common health complaint. Other less common conditions are asthma, heart problems, and epilepsy.

Children with chronic health conditions already in day care programs generally have mild forms of the problems, and most of the time are able to participate in the normal center routines. And even children with more severe forms of these conditions, or with less common chronic illnesses, can be involved in preschool programs with sound planning and caregiver preparation. (See Figure 36.) General information about each chronic condition can usually be obtained by contacting a voluntary agency associated with the disease (e.g., the American Lung Association for information on asthma).

It is important that you get detailed information from parents about their children's health problems, and you need to ask specific questions to get the "full story." The child's regular health record should include an additional page related to the child's chronic illness. (See Figure 37 for a sample form.)

In this chapter, the chronic health conditions you are most likely to see in preschool children will be described briefly. In addition, some less common conditions will be presented; children with these problems can be integrated into preschool settings also, but it is less likely that a day care center would have had any experience with them. Tips on how to accommodate these children into the regular daily program also are included. Suggestions for handling the special nutritional needs of certain chronically ill children are addressed in Chapter 12.

Figure 36

Considerations in Programming for Preschoolers with Health Impairments

	LEVEL I Mild	LEVEL 2 Mild to Moderate	LEVEL 3 Moderate	LEVEL 4 Severe
Is the Child Handicapped?	No	Possibly	Yes	Yes
How does it affect the child's functioning?	Health impairment does not interfere with day-to-day functioning and learning.	Health impairment does not interfere with learning, but there is a possibility of unusual episodes or crises.	Health impairment either presents frequent crises or so limits the child's opportunity to participate in activities that it interferes with learning.	Health impairment is so severe that special medical attention is regularly needed. The child's opportunity for activity is so limited that s/he may not be able to participate in a regular classroom.
Must the program be modified?	No.	No change in program planning is necessary. Watch for unusual occurrences and report them to parents or doctor. Know any first aid procedures that might be required.	Activities will have to be modified to allow a health-impaired child to participate. Staff must know proper first aid procedures and be prepared to deal with children's questions about crises.	Extensive staff and program changes are necessary to accept child into program. Home- or hospital-based programs may be more appropriate. Classroom support from medical services will be necessary if child is in classroom.

Adapted from: Mainstreaming Preschoolers: Children with Health Impairments, 1978.

Figure 37

Sample Chronic Illness Health Record

NAME OF CHILD: ____

1. Does the child have an ongoing health problem (chronic illness)? Check all that apply.

____ Allergies To What: ________________ ____________________________________	____ Heart trouble
	____ Kidney trouble
____ Anemia	____ Sickle cell disease
____ Asthma	____ Other: ________________
____ Diabetes	____________________________
____ Epilepsy/seizures	

2. What happens to the child when s/he has a crisis related to the condition?

3. What procedures would the day care staff follow to:

   a. prevent these crises?

   b. deal with them when they occur?

4. Does the staff need to be trained in any particular emergency procedures (e.g., CPR)? If so, which?

5. What medications does the child take?

   a. Are there any side effects (including behavioral)? From which medicines?

   b. Does the child need to have medication in day care? On what schedule?

Figure 37 (cont.)

6. Check all following program areas that require any changes. Tell us what changes or special arrangements need to be made.

   a.____Diet. What?

   b.____Order of activities. Describe:

   c.____Types of activities. Describe:

   d.____Length of activities. Describe:

   e.____Naptime routine. Explain:

   f.____Toileting. Explain:

   g.____Other. Explain:

7. Name of person(s) other than yourself(selves) to contact for questions about this child's condition if you are unavailable?

8. Any other information you feel we should have:

PERSON COMPLETING FORM: ______________________________
(Please Print)

DATE: ____________________

This chapter discusses the following chronic health conditions:

- Allergy
- Asthma
- Heart problems
- Epilepsy/seizure disorder
- Sickle cell anemia
- Diabetes

Allergy

■ WHAT IS IT?

An allergic reaction is a special type of inflammatory (swelling) response in various parts of the body to a foreign substance in the environment which most people tolerate without any problem. Hayfever, asthma, eczema, hives, and sinusitis are common allergic reactions.

■ HOW DO PEOPLE GET ALLERGIES?

It is thought that allergies largely are inherited from a parent or parents, though the parent may have only had allergies as a child, or may have had one type of allergy while the child has another.

■ WHAT TRIGGERS AN ALLERGIC REACTION?

The foreign substances that cause an allergic person's body to react are called *allergens.* These allergens may be swallowed, inhaled, or touched. Common allergens include:

- Indoor and outdoor dust
- Pollen from trees and weeds
- Mold from plants, dead grass, and leaves
- Animal fur and feathers; insect venom (bee or other insect stings)
- Foods such as eggs, nuts, chocolate, shellfish, cow's milk, and wheat (the last two are are especially common in infants)

■ WHAT ARE THE SYMPTOMS OF AN ALLERGIC "ATTACK" OR "EPISODE"?

When we say that a child is allergic, we do not mean that s/he is actually having symptoms all the time. What we mean is that s/he has a tendency to react under certain conditions.

For example, a child with an allergy to chocolate may be in perfectly good health unless s/he eats chocolates, in which case s/he may develop hives or abdominal pains.

Symptoms of an allergic reaction depend on which part of the body is especially sensitive to the allergen.

Allergens which are *inhaled* can cause:
- asthma attacks (see Asthma section)
- sneezing
- itchy eyes
- coughing

Allergens which are *ingested* (eaten) can cause:
- itchy throat
- nausea/vomiting
- diarrhea
- hives/skin rash

Allergens which are *touched* can cause:
- itchy/blotchy skin
- skin rash/hives

In extremely rare instances, a child will develop an overall allergic response which causes the voicebox to swell and makes breathing difficult. This anaphylactoid (swelling) reaction should be treated *immediately* by a physician, since it can be fatal. Some people have this kind of reaction to bee stings and need to have a bee sting kit available which contains an injection to treat the reaction.

■ WHAT IS THE TREATMENT FOR ALLERGIES?

The most effective approach to treating allergies for most children with mild problems is to figure out what specific allergens cause the reaction and then avoid them. Some allergens are treated by medications, either taken regularly (everyday or during certain seasons) or when the child is having allergic symptoms.

■ WHAT SHOULD DAY CARE STAFF DO DURING A CHILD'S ALLERGIC ATTACK?

The best advice is to use common sense: If the staff person can identify the allergen, s/he should either *remove the child from the allergic environment or take the irritant out of the child's space.* If the allergen cannot be easily identified, and the child's symptoms do not decrease, the staff member should *try to keep the child calm, quiet, and comfortable while s/he contacts the parent or physician.*

Parents should be required to leave for the day care provider detailed instructions on what to do if such a reaction occurs. (Use the Chronic Illness Health Record, Figure 37.)

HOW SHOULD DAY CARE CENTERS PLAN TO INTEGRATE CHILDREN WITH ALLERGIES?

Most children with allergies require no special planning at all; common sense is the key to handling these children successfully. For example, if a child develops uncomfortable itchy eyes one spring day on the playground, s/he should be brought inside. A child with a chocolate allergy should not be given chocolate birthday cake and, in fact, parents in the group with the allergic child could be asked not to bring chocolate cakes.

Some of the main problems in day care environments for allergic children are the following:

- Keeping pets such as rabbits, guinea pigs, and other furry animals
- Damp/moldy basement areas, bathrooms, etc.
- Field trips to farms, zoos; hikes in the woods, leaf fights, etc.

Modifications in your program or physical space may be required to avoid allergic reactions.

Asthma

WHAT IS IT?

Asthma is a respiratory problem in which breathing is difficult and often accompanied by a wheezing or whistling sound. This wheezing is caused by the following combination of events occuring in the lungs: the muscles surrounding the lungs tighten, the tissues lining the air tubes swell, and an extra amount of mucus is produced. The airways are narrowed because of these events, and air passing through makes a wheezing sound. Most children with asthma have "asthma attacks" only occasionally. At other times, they are fine.

HOW DO PEOPLE GET ASTHMA?

Asthma can be caused by allergic and nonallergic responses. Children with allergic asthma probably inherit the tendency from one or both parents. It is not yet clearly understood how children with nonallergic asthma develop it.

WHAT TRIGGERS AN ASTHMA ATTACK?

Since the lungs of a child with asthma are especially sensitive, a variety of factors can trigger an asthma attack including:

- Allergens such as dust pollens, molds, feathers (see Allergy section)
- Weather conditions such as cold air, weather changes, windy or rainy days
- Smoke, both cigarette and other types
- Odors, aerosols, such as paint fumes, cleaning materials, chemicals, perfumes, etc.
- Infections, especially viral respiratory tract infections
- Exercise, especially strenuous exercise in cold or damp weather
- Sleeping with head not raised, especially when the child has a cold

WHAT ARE THE SYMPTOMS OF AN ASTHMA ATTACK?

During an asthma attack, a child has discomfort or tightness in the chest, and has difficulty breathing. This is usually accompanied by the wheezing sound, especially when breathing out (exhaling). Sometimes coughing and spitting up of mucus (phlegm) are part of the episode. Asthma attacks can frighten a child, or s/he can appear tired and listless.

WHAT IS THE TREATMENT FOR ASTHMA?

Depending on the frequency of attacks and severity of the asthma, a range of treatments is available. Often, asthma attacks are mild and will calm down with rest or treatment within a short period of time. Keeping the child away from the irritants that are known to cause wheezing is the first step. Some children take regular medications which:

- relax airways, making it easier to breathe
- prevent exercise-induced asthma
- decrease inflammation (swelling)
- relieve nasal/sinus congestion, itching eyes, and sneezing.

Special equipment called *nebulizers* convert the medicine into a fine mist that can be inhaled. Some children with asthma use nebulizers on a regular basis or to treat an attack. Other children need asthma medications only during particular seasons, or when they have colds.

WHAT SHOULD DAY CARE STAFF DO DURING AN ASTHMA ATTACK?

Day care centers should have detailed instructions about what to do during an asthma attack, including what symptoms are particularly worrisome. An asthma record for each child is a must and should be attached to the child's general medical form. (See Figure 38 for a sample.) General guidelines include the following:

Figure 38

Sample Asthma Record

______________________________ ______________________________
Child's Name Physician's Name

1. Describe the child's asthma symptoms, including when they generally occur. What triggers an attack?

2. How are mild episodes ("attacks") treated?

3. How are serious episodes treated?

4. Is this child on daily medication?_________
   If so, give details below:

5. Are there any side effects of the medication (physical and/or behavioral)? If so, please explain.

6. Does strenuous activity induce episodes? __________
   If so, under which conditions should this child not participate in sports?

7. Do weather conditions affect the asthma? ___________
   If so, how?

8. Does the child understand asthma? ___________
   If yes, does the child participate in the management of this condition? _________ How?

ADDITIONAL COMMENTS: DATE:__________________

- Remove the child from the allergen if it is known.
- Try to keep the child calm, and try to help him or her to relax.
- Keep the child sitting upright rather than lying down.
- Encourage the child to drink fluids (nothing ice cold).
- Administer medications as indicated by parents and doctors.

HOW SHOULD A DAY CARE CENTER PLAN TO ACCOMMODATE CHILDREN WITH ASTHMA?

Most children with asthma can participate in the normal activities in a day care setting. Adults in contact with these children should know emergency procedures and what allergens to avoid in the classroom environment or in foods served. If a child tends to get asthma during exercise, day care staff should keep close watch during strenuous activity. If an asthma attack begins, the child should be kept quiet and encouraged to relax; after the attack, the child may be able to continue playing. Be sure to let parents know of the attack at the end of the day so that they can monitor the child's condition.

Parents of children with asthma know their children's limitations and should be consulted frequently so that the day care center does not unnecessarily limit the child's activity.

Heart Problems

WHAT ARE THEY?

The heart is a muscle that pumps blood through the body. It is divided into four hollow parts called chambers. The blood goes from the heart to the lungs where it picks up oxygen. The blood then returns to the heart which pumps the blood out to the body. As the oxygen is used up, the blood returns to the heart and the process begins again.

Heart problems occur when one or more of the following is not working properly:

- the pumping chambers
- the valves which separate the pumping chambers and keep the blood flowing in the proper direction
- the blood vessels leading to or from the heart.

HOW DO CHILDREN DEVELOP HEART PROBLEMS?

Most heart problems in children are congenital (present at birth). These congenital defects begin in the early part of pregnancy when the heart is forming. Heart disease also may occur in children who have had rheumatic fever, which is an unusual complication of strep throat. They are left with scarred valves which do not properly control the flow of blood between pumping chambers.

■ WHAT IS THE TREATMENT FOR CHILDREN WITH HEART PROBLEMS?

Many congenital heart defects are mild and do not require therapy. The most severe congenital heart defects and some heart disease from rheumatic fever can be corrected or vastly improved by surgery. Other heart defects can be treated with drugs or mechanical aids such as pacemakers.

Often children who have had rheumatic fever will take daily antibiotics to prevent them from catching another strep throat which could possibly cause further damage to their heart valves.

■ WHAT ARE THE SYMPTOMS OF HEART DISEASE?

Congenital heart problems can be identified in infants who have a bluish color, difficulty breathing, or abnormal growth and weight gain. These children as well as those with rheumatic heart disease may tire easily and feel weak, and, in general, have symptoms similar to children recovering from corrective surgery.

In most cases, heart problems are already known to parents before a child is enrolled in day care. However, in case they are not, it is important to alert parents to any such symptoms as they may indicate heart disease.

■ HOW CAN A DAY CARE CENTER ACCOMMODATE A CHILD WITH HEART PROBLEMS?

Children with heart problems not fully corrected by surgery, or children recovering from surgery may require modifications in the daily program because their stamina and endurance may not match that of other children. These modifications include:

- shorter active play periods
- additional rest periods; longer naps
- more frequent meals
- administration of regular medications.

It is important to obtain detailed information from parents and doctors describing the types and amounts of activities in which these children can participate. If you are uncertain if a child should take part in a particular event (e.g., dance and movement), get advice from the doctor and/or parent.

It is important that children with a history of rheumatic fever not contract strep throat. *If there are cases of strep throat in your center with a child who has had rheumatic fever, inform his/her parents immediately.*

Make sure to explain to the other children the reasons for the child's limited activity and provide him opportunities to excel in nonphysical areas. *Do not restrict the child beyond what is requested by doctors or parents.*

Epilepsy/Seizure Disorder

■ WHAT IS IT?

The brain serves as a master control center for almost all functions of the body including movement, thinking, feeling, and talking. It sends electrical charges along nerves to body parts and also receives and interprets these electrical signals.

Epilepsy is a disorder of the brain in which the brain sometimes becomes overloaded with electrical charges and produces a set of uncontrollable movements called seizures or convulsions. The loss of control is temporary, and the brain usually functions normally between seizures. Epilepsy is fairly rare compared to allergies; it is estimated that between one and two percent of all children have some form of ongoing seizure disorder. Among preschoolers, it is thought to be less than one child per 100.

The two most common types of seizures are "grand mal" and "petit mal" (absence) seizures:

- Grand mal seizures are the most dramatic seizures and affect the whole body. Grand mal seizures usually last only a few minutes. During this time, the person becomes unconscious, may shake violently, drool at the mouth, bite his/her lips, cheeks, or tongue. The person may also have no control over his/her bladder and bowel movements. A deep sleep may follow the seizure. In some cases, the seizure is preceded by a special feeling which differs from person to person. This warning sign is called an *"aura"* and enables the person to ready him/herself by lying on the floor to prevent a fall.

- Petit mal (absence) seizures are of very short duration. The child may seem to stare blankly, blink, or experience slight twitching, and then return to an activity. Though this behavior is often mistaken for "daydreaming," a child experiencing an absence seizure cannot be roused out of the seizure, as one can do with a daydreaming child. Petit mal seizures are most common in young children.

■ HOW DO CHILDREN GET EPILEPSY?

There are many different known causes of seizures in children, including:

- high, rapidly rising fever
- infection such as viral encephalitis
- metabolic or body chemistry imbalance
- head injury/trauma (complication at birth or afterwards)
- poisoning, such as lead poisoning

Heredity may also be a factor. For many children with epilepsy, however, there is no explanation for the brain's malfunctioning.

■ WHAT TRIGGERS AN EPILEPTIC SEIZURE?

Some children's seizures have known "triggers" including fatigue, blinking lights, "scary" amusement rides such as roller coasters, certain sounds or odors, or even high fever itself. For other children there are no known triggers.

■ WHAT IS THE TREATMENT FOR EPILEPSY?

At present, there is no cure for epilepsy. However, almost half of all people with epilepsy have their seizures completely controlled by medications and other treatments. An additional 30% of people with epilepsy have their seizures substantially, although not totally, controlled.

Most children with epilepsy will be taking daily medications. Information on the medication, possible side effects, and seizure triggers should be obtained from parents and physicians.

■ WHAT SHOULD DAY CARE CENTER STAFF DO DURING A GRAND MAL SEIZURE?

Although a grand mal seizure appears frightening, it is not dangerous to the child and generally will pass without complications. The following steps should be taken by staff members during a grand mal seizure:

- Remain calm.

- If child is on the floor, leave him/her there; if child is elsewhere, place him/her on the floor, on either side.

- Clear the area of sharp, pointed objects which are hard or hot.

- Place soft pillow or clothing under child's head.

- Turn the child on his/her side so the child can breathe and saliva cannot collect in his/her throat.

- Stay with the child until the seizure ends (usually 2-3 minutes) and help him/her to a comfortable place to rest for a while.

- Reorient the child to activities.

- Have a treatment plan prepared for seizures which last more than five minutes (status epilecticus). Emergency contacts and transportation to a hospital should be arranged immediately.

- Make sure the child doesn't hurt himself by knocking against something.

- Loosen tight clothing.

- Do not try to interfere with or stop the seizure movements (except to prevent serious injury).

DO NOT PLACE ANY STICKS OR OTHER OBJECTS IN THE MOUTH DURING A SEIZURE!!!

It is critical that the child not be made to feel "freaky" after a seizure. To help normalize the experience, the day care teacher should discuss seizures with the child's group so they will be prepared. *Remember there is no way to stop a seizure once it has begun,* except by methods available to physicians.

■ WHAT SHOULD A DAY CARE CENTER DO TO INTEGRATE A CHILD WITH EPILEPSY?

Most children with epilepsy take medication to control their condition and therefore no special planning is needed for them. It is important, however, to train staff in emergency procedures and get complete medical information from parents and physicians. In the case of children who have occasional seizures, the staff should know which activities might be dangerous and should prepare the other children to be helpful if they see a grand mal seizure.

As with other conditions, the child with epilepsy should not be restricted from participating in the full program, unless specific limitations are imposed by parents or physicians.

Sickle Cell Anemia

■ WHAT IS IT?

Anemia is a general term for a blood disorder caused by too few red blood cells or too little hemoglobin -- the pigment that gives the red blood cells their color. These red blood cells are important to the breathing process and they feed the body's other cells; therefore, people with anemia often seem tired or without much energy.

With sickle cell anemia, the normal round red cells take on a sickle shape, and they do not contain the correct amount of oxygen. They have difficulty moving through the smaller blood vessels, and become damaged or destroyed. Sickle cell anemia is most commonly found in black children and young adults.

■ HOW DO PEOPLE GET SICKLE CELL ANEMIA?

Sickle cell anemia is a disease which children inherit from their parents. Parents may be unknowing "carriers" and pass the defective gene on to their children. Both parents must pass on a defective gene to produce a child with sickle cell anemia, but either parent can pass on a defective gene to produce a child who carries the sickle cell *trait.*

■ WHAT HAPPENS DURING A SICKLE CELL CRISIS?

Sickle cell anemia affects children differently. A small percentage are able to participate in all activities, but a far greater number have intermittent periods of fatigue and pain. When a large number of sickled cells stick together in a blood vessel, the blockage is called a "crisis." It usually causes extreme pain in the place where it occurs. Common locations are the hands, feet, legs, and abdomen.

■ WHAT TRIGGERS A SICKLE CELL CRISIS?

A sickle cell crisis can be set off by an infection, fatigue, unusual stress, or overexertion. At times, a crisis occurs without any identifiable trigger.

■ WHAT IS TREATMENT FOR SICKLE CELL ANEMIA?

Sickle cell anemia is not curable, although it can sometimes be controlled by medication. Its complications can often be treated. Children with sickle cell anemia should avoid overexertion and infections. Some children with sickle cell anemia require hospitalization to deal with painful crises and infections.

HOW SHOULD A DAY CARE CENTER PREPARE TO INTEGRATE A CHILD WITH SICKLE CELL DISEASE?

Because a child with sickle cell disease is particularly vulnerable to infection, the decision to place such a child in a group care setting is a delicate one which should be reached jointly by parents, physicians, and staff. A child with a mild case may be able to participate fully in day care and should be encouraged to do so. You should have detailed information on the child's ability to engage in physical activities, beginning symptoms of illness or infection, and procedures to handle a sickle cell crisis should it occur. A well-considered way to discuss the child's illness with other children in his/her group is necessary.

Detailed emergency procedures must be available as well as several possible contact persons who know about the condition.

Diabetes

WHAT IS IT?

Diabetes is a condition in which the pancreas, a gland located behind the stomach, does not produce enough of a natural chemical called *insulin.* Insulin is a very important substance, since it helps the body store and use (metabolize) sugar (glucose). All cells in the body need glucose to work properly, since it is their main fuel or food for energy. Without insulin, these cells cannot use the glucose already in the blood and do not get enough nourishment.

There are two forms of diabetes:

- Insulin-dependent diabetes (also called Type I or juvenile-onset diabetes).

- Non insulin-dependent diabetes (also called Type II or maturity-onset diabetes).

Almost all children have the insulin-dependent form, which means they must add insulin to their bodies daily through injections, usually two each day. In addition to the insulin, each child needs to follow a special diet; insulin and diet must be balanced with exercise. Food makes the glucose (blood-sugar) level rise; exercise and insulin make it fall.

Problems can result from an imbalance among these factors. The most common reaction, when blood-sugar level is too low, is called an *insulin reaction.* Much rarer is a blood sugar level which is too high; this results from too little insulin and is called a *diabetic coma.* This does not come on suddenly and generally need not concern day care personnel.

■ HOW DO CHILDREN GET DIABETES?

The exact causes of diabetes are not yet known. However, it is generally thought that a child inherits diabetes, and many diabetic children have a family history of the disease.

■ WHAT IS THE TREATMENT FOR DIABETES?

Most insulin-dependent diabetic children must have insulin injections twice daily. They must stay on a diet which is specifically planned for their normal activity level and temperament. Exercise is necessary to control diabetes. Finally, using a simple procedure several times each day, their blood or urine should be tested to determine the blood sugar level.

Although diabetes is not curable, in most cases it can be controlled so that children may lead full lives.

■ WHAT TRIGGERS AN INSULIN REACTION?

An insulin reaction occurs when the glucose level is too low, either because of too much exercise or too little food. The onset of an insulin reaction is usually sudden.

■ WHAT ARE THE SYMPTOMS OF AN INSULIN REACTION?

The following are warning signs that an insulin reaction is going to occur. Often a child will feel these symptoms coming on and alert a staff member.

- staggering/poor coordination
- irritability/unusual behavior
- pale color/sweating
- confusion/disorientation
- excessive hunger
- trembling/crying
- headache and dizziness
- abdominal pain or nausea
- blurred vision
- drowsiness/fatigue.

IF AN INSULIN REACTION IS NOT TREATED IMMEDIATELY, UNCONSCIOUSNESS AND CONVULSIONS MAY OCCUR.

■ WHAT SHOULD A STAFF MEMBER DO DURING AN INSULIN REACTION?

- Provide sugar immediately in the form of orange juice, other sugar-containing juice, or granulated sugar.
- Reassure the child.
- If there is no improvement within 10-15 minutes, call parents or physician.
- When the child is feeling better, s/he should have a small snack, and then resume activities.
- The procedures to follow during an insulin reaction should be approved in advance by the parents and physicians.

■ HOW SHOULD A DAY CARE CENTER PREPARE FOR A CHILD WITH DIABETES?

- Basic information about the child's diabetes should be collected prior to enrollment using the standard Chronic Illness Health Record (Figure 37). Additional information on emergencies that may occur should be noted as well. Make sure that you get information on these additional items:
    - Signs and symptoms the child usually exhibits before an insulin reaction
    - When insulin reaction is most likely to occur
    - Most effective treatment and amount
- All staff should be acquainted with the signs of an *insulin reaction* and how to treat it. A posting of general procedures in each classroom would be helpful.
- Make sure that every staff member has quick access to sugar or the sugar-containing foods suggested by the child's physician.
- Meal preparations must be according to the child's special requirements. Meal plans should be worked out with the parents and/or consulting dietician.
- Meals and snacks must be given on time.
- Have the child eat an extra bit of food before strenuous exercise, if prescribed.
- Staff may be asked to assist in monitoring the child's blood sugar level. Review this or any other special requirement with the parent and physician.

- Explain to the other children about insulin reactions so they can inform an adult if a reaction occurs.

Children with diabetes should not be unduly restricted from involvement in all activities.

Review of Emergency Planning Procedures

The following summary points, adapted from Mainstreaming Preschoolers, apply to all programs serving children with chronic conditions.

- Prepare for emergency situations by talking to parents or the child's doctor.

- Be aware of what may cause a crisis and how often it may occur.

- Be aware of how the child may behave before a crisis.

- Know what behaviors the child is likely to have during and after crisis, and how long it usually lasts.

- Ask the parent/doctor to describe, demonstrate or train you in what you are to do during and following the crisis. Can you do it alone or should you get help?

- Prepare a list of your classroom activities; ask child's doctor to check activities which must be avoided and to describe modifications so the child can participate.

- Prepare other children for possible health crises by giving them a simple explanation when discussing other emergencies; assure children that the staff will be able to handle all such situations.

References

Black, E. and Nagel, D. (Eds.). Physically Handicapped Children: A medical atlas for teachers (Second Edition). New York: Grune and Stratton, 1982.

Booth, A., Donsbad, P. and Maykut, P. Mainstreaming Children with a Handicap in Day Care and Preschool: A manual of training activities. Madison, WI: Wisconsin Council on Developmental Disabilities, 1981.

Boston Children's Medical Center and Feinbloom, R.I. Child Health Encyclopedia: The complete guide for parents. New York: Delacorte Press/Seymour Lawrence, 1975.

City of Boston. Mayor's Commission on the Handicapped/Boston Public Schools, Department of Student Support Services. Chronic Health Problems: The special needs booklet series. Boston: City of Boston, 1982.

Freudenberg, N., Feldman, C., Clark, N., Millman, E.J., Valle, I., and Wasilewski, Y. The impact of bronchial asthma on school attendance and performance. Journal of School Health 50: 522-526 (1980).

Healy, A., McAvearcy, P., Von Huppel, C.S. and Jones, S.H. Mainstreaming Preschoolers: Children with health impairments. Washington, DC: US Dept. of HHS/Office of Human Development Services. DHHS Publication No. OHDS 80-31111, 1978.

Understanding Handicaps of Newton, Inc. Unit V: Special medical problems. Newton, MA, 1983.

Pamphlets, booklets, and information sheets from the following voluntary agencies:

American Diabetes Association
American Heart Association
American Lung Association of Massachusetts
Boston Sickle Cell Center
March of Dimes Birth Defects Foundation
Sickle Cell Disease Research Foundation

For more information about organizations and agencies, contact Federation for Children with Special Needs, 32 Stuart St., Boston, MA 02111, (617) 492-2915.

Introduction

As you have already learned, there is a great deal that you can do to prevent the spread of disease in day care. Proper handwashing and environmental controls *can* decrease the amount of illness. Nevertheless, there are times when children and adults will become ill at day care or as a result of attending day care. In those cases, you need to be aware of the symptoms of the illness and what you are to do at day care.

Some illnesses are acute (present for a short time) and some are chronic (ongoing). You will see both types among the children and adults in day care. Some illnesses are annoying, but mild, and some can be very dangerous.

Day care can play a very helpful role for children and parents by managing minor illnesses which do not require a child to be at home. Most children with chronic illnesses can be cared for in day care settings as well.

This section of Health in Day Care will present an overview of illnesses that you may see in day care. Use it as a reference for yourselves and for parents. Your partnership with parents and health providers will help you deal effectively with illnesses as a team.

This section of the manual includes the following chapters:

- Chapter 17: Infectious Diseases
- Chapter 18: Care of the Mildly Ill Child
- Chapter 19: Sick Child Care Models

Throughout this section, the following major concepts are highlighted:

1. Every center should have detailed policies about handling illness, including policies about attendance when ill.
2. Despite your best efforts, children will get sick. It is an expected part of life.

3. You can do a great deal to prevent the spread of disease by following the appropriate precautions.

4. It is important that you become familiar with signs and symptoms of illness. In some cases, though rare, it is important that you seek medical attention.

5. Most children who are mildly ill can safely attend the center if they feel well enough to come. Most illnesses do not require exclusion.

6. Options available for sick child care should be discussed with parents at enrollment.

17 Infectious Diseases

Introduction

Infectious diseases are illnesses caused by infection with specific microorganisms -- viruses, bacteria, fungi, or parasites. Infectious diseases that can spread from one person to another are called *contagious* or *communicable* diseases.

These contagious illnesses are one of the major problems that face day care centers. They are a cause of both staff and child absence, not to mention discomfort.

The organisms that cause infectious and contagious diseases are spread in four main ways:

- through the intestinal tract (intestines and stools)
- through the respiratory tract (eyes, nose, mouth and lung secretions or fluids)
- through direct contact (or touching).
- through blood contact

This chapter will give you information about some of the infectious diseases that can spread in child care settings. It will also discuss some common infections which *are not* contagious. For each disease and for some groups of similar diseases (for example, infectious diarrhea), the following questions will be addressed:

- What is it? (What are they?)
- Who gets it (them)?
- How do people get it (them)?
- How is it diagnosed?
- How is it treated?
- Should people be excluded or sent home?
- When can they come back?
- Where to report it?

In addition, guidelines on how to *STOP SPREAD* are given for each disease, and, for some diseases, sample letters to parents are included.

Some of the actions discussed are required by the laws or regulations of the State Department of Public Health or the Office for Children. For example, immunizations are required before chidren can enter group day care. Other actions or practices are recommended by the Department of Public Health, Division of Communicable Disease Control, as ways to reduce the spread of infectious disease and to assure that illnesses receive appropriate treatment. They are based on the best information and current policy recommendations available at the time of writing this Guide.

If you have any questions about any of the information or recommendations in this chapter, you should talk first with your health consultant and your local Board of Health. If you need more information or clarification, you can contact the Division of Communicable Disease Control (617-727-2686).

The topics and diseases to be discussed are shown in the following outline.

The Five Commandments of Infectious Disease Control in Day Care

1. Prevent illness from spreading.
2. Require certain immunizations.
3. Report some illnesses.
4. Exclude some children.
5. Be prepared!

Diseases Spread Through the Intestinal Tract

General Principles
Infectious Diarrhea
- Giardia Lamblia
- Shigella
- Salmonella
- Campylobacter

Pinworms
Hepatitis A

Diseases Spread Through the Respiratory Tract

General Principles
Common Illnesses
- Respiratory Viral Illnesses ("Colds," Influenza, and Roseola)
- Group A Streptococcal Infections ("Strep Throat," Scarlet Fever)
- Chickenpox (and Shingles)

Serious Illnesses
- Meningococcal Illnesses
- Haemophilus Influenzae Type B Illness (Hib Disease)
- Tuberculosis (TB)

Diseases Spread Through Direct Contact

Superficial Infections/Skin Infections
- General Principles
- Impetigo
- Ringworm (Tinea)
- Conjunctivitis (Pink Eye)
- Scabies
- Pediculosis (Head Lice)

Generalized Infections/Total Body Infections
- General Principles
- Cytomegalovirus (CMV) Infection
- Herpes Simplex Infections
- Sexually Transmitted Diseases

Diseases Spread Through Blood Contact

General Principles
Hepatitis B
AIDS/HIV Infections

Vaccine-Preventable Diseases

General Principles
Measles
Mumps
Rubella
Polio
Diphtheria
Tetanus
Pertussis (Whooping Cough)

Non-Contagious Infectious Diseases

Otitis Media (Middle Ear Infection)
Monilial (Candida) Infections (Thrush, Yeast Diaper Infections)
Tick-borne Diseases

The Five Commandments of Infectious Diseases Control

■ 1. PREVENT ILLNESS FROM SPREADING

"AN OUNCE OF PREVENTION IS WORTH A TON OF CURE."

- *Infections are spread from one person to another by body secretions* (saliva, tears, nasal discharge, urine, stool, phlegm, mucus, vomitus, blood, pus, ooze, etc.). Sometimes these secretions are scattered around by sneezing, coughing, blowing the nose, or by wet or dirty diapers. Sometimes these secretions (and the germs) get into food or drink or onto surfaces or objects and then are eaten or touched by another person.

- *Infection is often spread by people who don't look or feel sick.* Illness is often spread by people for several days *before* they feel or look sick. Some people have such mild illness that they never realize they're sick but they still infect other people.

- *Viruses and bacteria like warm, wet and stuffy and hate clean, dry and fresh.*

- Babies and small children cannot control their bodily secretions or keep themselves clean and dry. *Therefore, illness can spread quickly in groups of young children.*

To prevent the spread of infection, keep the center and the people clean, dry, and surrounded by fresh air.

Specific Recommendations

- *Fresh air* is important.
  Even in very cold weather, windows and doors should be opened at least once a day and the center thoroughly aired out (when children are not there).

- *Enough space for the number of people is important.*
  Crowding leads to the spread of infection. Cribs should have three feet between them. OFC regulations require at least 35 square feet of floor space per child. Discourage children from crowding into small areas.

- *Learn how to sneeze and cough.*
  Sneezing and coughing should be aimed toward the floor and away from other people. If you sneeze or cough into your hands, you will have to wash them! *Teach children to cough or sneeze toward the floor.* Otherwise they should cough or sneeze into a tissue, then wash their hands.

- *Handwashing Is Critical.*
  Babies' and children's hands should be washed:

  a. *Before* eating/preparing food
  b. *After* toileting/diaper changes
  c. *After* handling body secretions or using a tissue
  d. Ideally, *upon arriving* at the center

Adults should wash their hands:

  a. *Before* beginning work each day
  b. *Before* preparing food, helping babies/children eat, or eating themselves
  c. *After* changing diapers, toileting a child or going to the bathroom themselves
  d. *After* using a tissue on themselves or a child or touching body secretions.

Use free running water. Do *not* use stoppered sinks or basins for handwashing -- the germs will easily move from one child to another. Liquid or powdered soap, individually dispensed, is better than bar soap.

If absolutely necessary, individual towelettes may be used instead of soap and water. Any commercially available brand of towelettes is fine; they all contain alcohol as a moistener. Do not use diaper wipes, as these usually contain oil, not alcohol.

Use individual or paper towels for drying. Don't use the same towels for everyone -- the germs will just get spread.

- *Cleanliness Is Critical.*
  The diaper changing surface must be washed and disinfected after each diaper is changed even if a disposable cover is used. Use a standard bleach solution (1/4 cup bleach to one gallon water) or other disinfectant, then dry with paper towels.

  Keep dirty diapers in a *covered container*; use *plastic liners* in the container. A foot pedal is ideal.

  Wash and disinfect the toilets, sinks, and *diaper pail* at least once daily.

  Wash and disinfect mouthed toys at least once daily.

  Wash table surfaces with hot, soapy water, spray with bleach solution, then wipe dry, after each use. Do not let children share cups, spoons, etc. A dishwasher is ideal.

Do not allow the sharing of personal items or clothing (such as hats, cups, and combs) or sleeping mats/cribs/pillows.

Keep children as clean and as dry as possible. Examples:
- Change diapers and soiled clothes promptly.
- Wipe wet noses, eyes; hands, with paper tissues. Then wash *your* hands.
- If a child gets a scrape, cut, insect bite, or scratch, wash it well with soap and water, then cover lightly. Then wash *your* hands.

Any cleaning that involves blood should be done with a *strong bleach solution* -- one part bleach to ten parts water.

Refer to Chapters 3 and 4 on Environment and Sanitation for more detail.

■ 2. REQUIRE CERTAIN IMMUNIZATIONS

All children entering day care centers must be immunized against the diseases of diphtheria, tetanus, pertussis, poliomyelitis, measles, mumps and rubella in accordance with criteria established by the Massachusetts Department of Public Health. Children not properly immunized must be excluded. Religious and medical exemptions are allowed.

Figure 39 gives information designed to assist you in detemining whether additional immunizations may be needed to meet state requirements for day care entrance.

Figure 40-A shows the childhood immunization schedules currently recommended by the Massachusetts Department of Public Health. Ideally, these schedules would not be interrupted. Most children would have all the immunizations they need and would complete their basic series of immunizations before the age of two years. In reality, appointments are missed, and schedules are delayed or altered for one reason or another. However, it is never too late to start or finish immunizations; an interruption in the schedule does not mean starting them all over. (See Figure 40-B.) All vaccines must be taken for complete protection; partial immunization does not insure against disease. This is why making sure of immunization status upon entry to any group setting (day care or school) is so important.

In addition to the mandated immunizations, another immunization is now recommended by the Department of Public Health for all children in group day care who are 18 months of age and over. It is a newly licensed vaccine against Hib disease (Haemophilus influenzae type B).

Figure 39

Immunizations Required for Day Care Children

Immunizations are administered according to schedule. To assist you in determining which immunizations are needed, the following chart was developed.

IF A CHILD IS THIS AGE:	*S/HE SHOULD HAVE RECEIVED:*
2-4 months	1 DTP, 1 Polio
4-6 months	2 DTP, 2 Polio
6-15 months	3 DTP, 2 Polio
15-18 months	3 DTP, 2 Polio, MMR
18 months-Kindergarten	4 DTP, 3 Polio, MMR

CODE: DTP - Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed
Td - Tetanus and Diphtheria Toxoids Adsorbed (for age 7 and older)
Polio - Trivalent Oral Polio Vaccine
MMR - Measles, Mumps, Rubella

Measles Mumps and Rubella (MMR): One dose of MMR vaccine should be administered on or after 15 months of age. However, the child does not need to be reimmunized if immunized on or after the first birthday.

Children whose schedule has been interrupted and are in the process of being immunized [i.e awaiting the next DTP or polio dose and in the specified interval between doses (waiting period)] may remain in day care centers until the next dose is due. Those who exceed the specified interval must be excluded.

Figure 40

Recommended Immunization Schedules:

A. Childhood Immunization Schedule

The following schedules are recommended by the Massachusetts Department of Public Health. Some doctors may vary the schedule to meet individual needs.

AGE	*VACCINES*
2 mos.	DTP 1, Polio 1
4 mos.	DTP 2, Polio 2
6 mos.	DTP 3
15 mos.	MMR
18 mos.*	DTP 4, Polio 3
18 mos.	Hib**
4-6 yrs. (school entry)	DTP 5, Polio 4
Every 10 yrs.	Td

*May be given at 15 months with the MMR.
**New vaccine; not yet required for school entry or day care.

B. Children Not Immunized in Early Infancy or Behind Schedule

TIME INTERVAL	*AGES*	
	UNDER 7 YEARS	*7 YEARS AND OLDER*
First Visit	DTP 1, Polio 1 MMR (15 mos. or older)	Td 1, Polio 1, MMR
2 months later	DTP 2, Polio 2	Td 2, Polio 2
2 months later	DTP 3	
6-12 mos. later	DTP 4, Polio 3	Td 3, Polio 3
School entry*	DTP 5, Polio 4	
Every 10 yrs.	Td	Td

*Not required if DTP 4 and Polio 3 were given after 4 years of age.

CODE: DTP - Diphtheria and Tetanus Toxoids and Pertussis Vaccine Adsorbed
Td - Tetanus and Diphtheria Toxoids Adsorbed (for age 7 and older)
Polio - Trivalent Oral Polio Vaccine
MMR - Measles, Mumps, Rubella
Hib - Haemophilus influenzae type B Vaccine

Figure 41 shows the Certification of Immunization form that the State Department of Public Health provides to health care providers. You can obtain accurate immunization information from this form; encourage parents to ask for them from their health care providers.

Further information on vaccine-preventable diseases and on Hib disease can be found later in this chapter.

■ 3. REPORT SOME ILLNESSES

Certain diseases are required by law to be reported to the local Board of Health by the person making the diagnosis. Reporting of these diseases enables the Board and the state Department of Public Health to start an investigation and take appropriate measures to prevent further spread of disease. Any *outbreak* of a suspected infectious disease should also be reported (more than three children or staff with the same disease symptoms). Throughout this Guide, when you are asked to report an illness to your local Board of Health, this means to the Board of Health in the city or town in which your *center* is located.

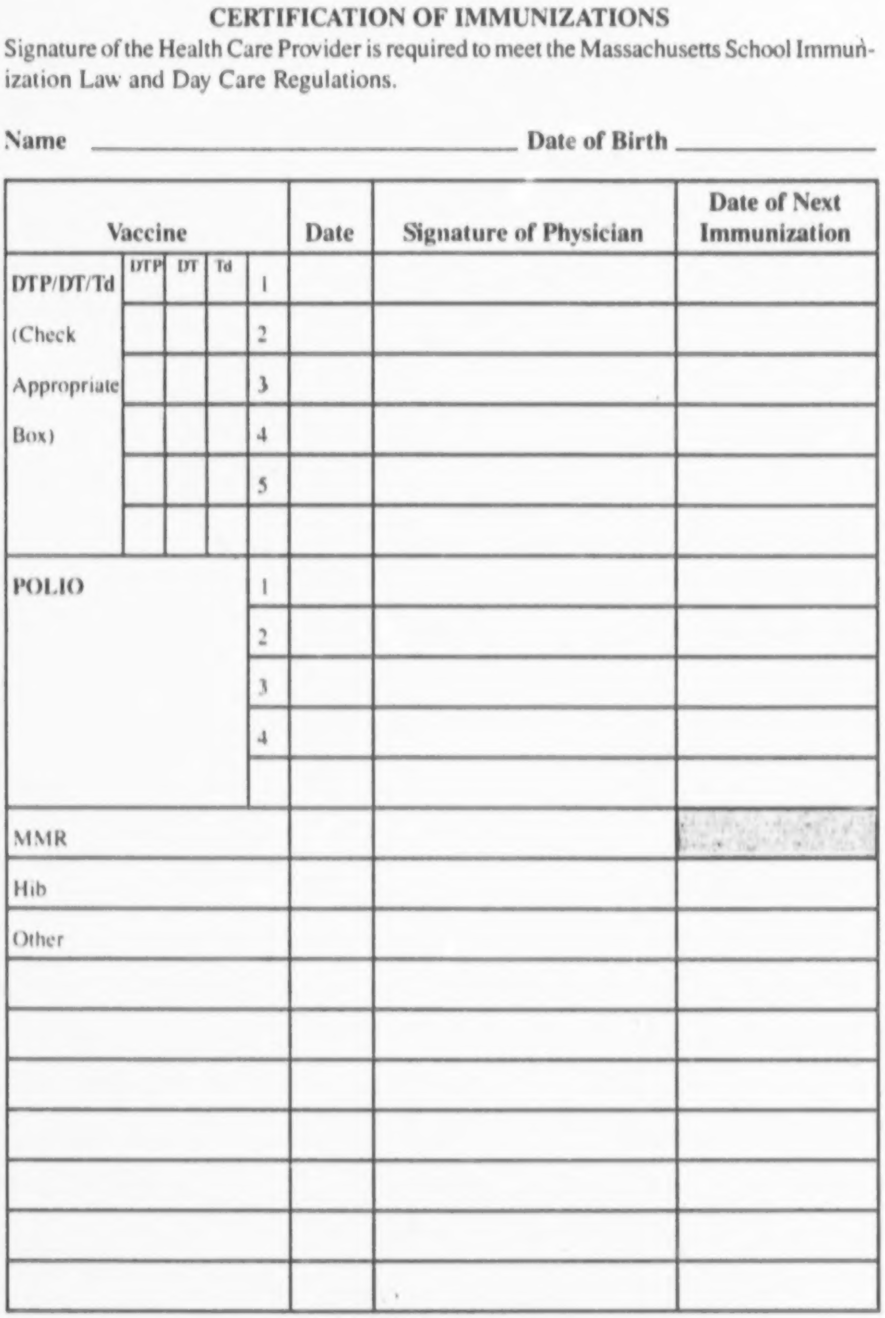
Figure 42 lists the current Department of Public Health regulations regarding reportable diseases and lists all diseases that must be reported. The content of these as they apply to day care centers is summarized below.

Reportable Diseases

Any of the listed diseases should be reported to your local Board of Health (the Board in the city or town where the center is located) when you become aware that a child or staff person has been diagnosed with one. You should also notify your health care consultant. See the later sections on individual diseases for more information on who else should be notified. (If your center experiences a case of one of the more rare diseases which we do not discuss in detail, your health consultant and local Board of Health will be able to advise you on next steps.)

In addition, an epidemic (a large number of cases in a short period of time) of *any* disease, even if not on the list, should be reported to the local Board of Health. An example would be a large number of cases of flu, mononucleosis, conjunctivitis, or pneumonia. This would be very unlikely to occur in a day care center.

Figure 41
Certification of Immunization Form



CERTIFICATION OF IMMUNIZATIONS

Signature of the Health Care Provider is required to meet the Massachusetts School Immunization Law and Day Care Regulations.

Name ______________________________ **Date of Birth** ______________

Vaccine	DTP	DT	Td		Date	Signature of Physician	Date of Next Immunization
DTP/DT/Td				1			
(Check				2			
Appropriate				3			
Box)				4			
				5			
POLIO				1			
				2			
				3			
				4			
MMR							▨
Hib							
Other							

Figure 42
Reportable Diseases

The diseases listed below shall be reported by telephone or in writing immediately, but in no case exceeded by 24 hours, to the board of health in the community where the case is diagnosed. In addition, all epidemics of any disease, including those which do not appear in this list of reportable diseases, shall be reported to the local Board of Health. The local board's responsibility upon receipt of a report is set forth in Massachusetts regulations 105 CMR 300.110 and 300.130.

- Amebiasis
- Animal Bite
- Anthrax
- Babesiosis
- Brucellosis (Undulant Fever)
- Chickenpox (Varicella)
- Cholera
- Diphtheria
- Encephalitis (specify type, if known)
- Epidemic Staphylococcal Infection of Newborn (onset within 30 days after birth)
- Foodborne Intoxications:
  - a. Botulism
  - b. Mushrooms and other poisonous vegetables and animal products
  - c. Mineral or inorganic poisons such as arsenic, lead, etc.
  - d. Staphylococcal
  - e. Paralytic shellfish poisoning
  - f. Other
- Giardiasis
- Haemophilus influenzal systemic infection (without meningitis)
- Hepatitis, Viral
  - a. Type A
  - b. Type B
  - c. Type Non-A, Non-B
  - d. Undetermined
- Kawasaki Disease
- Legionnaires' Disease (Legionellosis)
- Leprosy (Hansen's Disease)
- Leptospirosis
- Listeriosis
- Lyme Disease
- Malaria
- Measles (Rubeola)
- Meningitis: bacterial, viral, other
- Meningococcal Infection (without Meningitis)
- Mumps
- Pertussis (Whooping Cough)
- Plague
- Poliomyelitis
- Psittacosis
- Rabies (Human or Animal)
- Reye's Syndrome
- Rickettsial Disease:
  - a. Rickettsialpox
  - b. Typhus
  - c. Rocky Mountain Spotted Fever
  - d. Other
- Rubella (German Measles)
  - a. Congenital
  - b. Non-congenital
- Salmonellosis (including Typhoid and Paratyphoid Fever
- Shigellosis (Bacillary Dysentery)
- Tetanus
- Toxic Shock Syndrome
- Toxoplasmosis
- Trichinosis
- Tuberculosis
- Tularemia
- Yersiniosis

Illness Believed Due to Food Consumption

Every physician, superintendent or other person in charge of any school, day care, hospital, institution, dispensary, laboratory, labor camp or other camp who shall have knowledge of the occurrence of a number of cases of illness believed to have been due to the consumption of food, shall report the same immediately by telephone to the local board of health.

Diseases Reportable by Local Boards of Health to the Department of Public Health

Whenever there shall occur in any municipality an outbreak of suspected food poisoning or an unusual incidence of diarrheal and/or febrile illnesses, it shall be the duty of the local board of health to report immediately by telephone the existence of such an outbreak to the Department of Public Health.

Diseases Reportable Directly to the Department of Public Health

The following dangerous disease is reportable directly to the Department of Public Health:

- Acquired Immune Deficiency Syndrome (AIDS)

The following sexually transmissible diseases and syndromes are reportable directly to the Department of Public Health on special forms provided upon request:

- Chancroid
- Chlamydial Infection (Genital)
- Gonorrhea
- Granuloma inguinale
- Herpes Neonatal (onset within 30 days after birth)
- Lymphogranuloma venereum
- Ophthalmia neonatorum
    a. Gonococcal
    b. Other Agents
- Pelvic Inflammatory Disease
    a. Gonococcal
    b. Other agents
- Syphilis

Illnesses That May Be Due to Food Consumption

Day care directors are among the persons who are *required* to report to a local Board of Health *immediately by phone* when they are aware that a number of cases of illness (a "cluster") have occurred that they believe are caused by eating food. Examples of such a situation include:

a. a number of staff and/or children becoming ill suddenly (stomach cramps, vomiting, dizzy, etc.) shortly after eating lunch;

b. the center has been experiencing a lot of diarrheal illnesses and the cook informs you that she has just been tested positive for Salmonella.

Other Requirements

After certain disease patterns are reported to the local Board of Health, the local Board has a responsibility to report them to the state Department of Public Health. These include outbreaks of suspected food poisoning or an unusual rate of diarrheal illnesses and/or illnesses with fever. The state will then follow up and may be in touch with you for further information, testing, or preventive measures.

Finally, there are a number of diseases -- sexually transmitted diseases and AIDS -- which are reportable *directly* to the state Department of Public Health. Physicians or health care providers who diagnose these diseases are the mandated reporters. (See sections on Sexually Transmitted Diseases and AIDS later in this chapter.)

In certain instances, the disease your day care center reports will require special treatments or control measures. The State Department of Public Health provides certain preventive treatments at no cost to the public. These include immune globulin to prevent Hepatitis A and vaccines to prevent measles, mumps, rubella, diphtheria, tetanus, pertussis, and polio. Diagnostic tests such as tuberculin skin tests (Mantoux), stool cultures, and blood tests to detect certain infections are also provided free of charge when done as part of an outbreak investigation.

■ 4. EXCLUDE SOME CHILDREN

When Should A Center Absolutely Refuse to Let A Child Attend In Order to Protect Other Children and Staff?

Contrary to popular belief and practice, there are very few illnesses for which children need to be excluded from day care because of the health risk they pose for other children and staff.

For most conditions, either a child has *already exposed* others before becoming obviously ill (colds) *or is not contagious after beginning treatment* (strep throat, conjunctivitis, impetigo, TB, ringworm, parasites, head lice, and scabies). The time after beginning treatment and returning will vary depending on the specific disease.

But there are times when children do present a health risk to other children and staff and should stay home. Specific information about exclusion or the need to send children home during the day is provided under each disease section in this chapter. Please refer to these individual sections.

In some cases, it may be appropriate for the child to attend the center *only if* the center can take *SPECIAL PRECAUTIONS*. These are also explained under the individual diseases.

Children who are *carriers* of some viral illnesses, such as Herpes *can be and should be admitted to day care* without posing a significant threat to the health of others.

When Should a Center Exclude Ill Children for Reasons Other Than to Protect Other Children and Staff?

There is no one right answer to this question. Many centers exclude children who are too ill to participate in their usual activities. *BUT REMEMBER, WORKING PARENTS UNIFORMLY WISH CENTERS COULD CARE FOR MILDLY ILL CHILDREN.*

To better meet their needs, consider:
- Maintaining a small room/quiet area where mildly ill children may spend a quiet day.
- Assigning one staff person to stay inside with mildly ill children while others go outside.
- Facilitating a network of back-up homes or caretakers for ill children that parents can use as a resource.

Refer to Chapters 18 and 19, Care of the Mildly Ill Child and Sick Child Care Models, for more information.

■ 5. BE PREPARED!

DON'T WAIT UNTIL AN EPIDEMIC HITS - DO SOME ADVANCE PLANNING.

- Insist that staff learn and follow guidelines on handwashing, cleaning, and ventilation. *This is the single most important way to prevent outbreaks of infectious disease.*

- Choose a *health consultant* who knows about infectious disease in centers or is willing to learn.

- ☎ Have ready the phone numbers of your local Board of Health and the state Department of Public Health/Division of Communicable Disease Control (617-727-2686, Ext. 420).

- Before a child begins attending your center, make sure immunizations are up to date or in progress. *Check immunization status at least once a year.* This is important not just because OFC requires it, but because these diseases can still occur in unvaccinated populations.

- Make sure you find out when children or staff have a communicable disease. Send a letter home with children each year asking parents for their help and asking them to:

  - Call or write when their child is ill and tell you the problem.
  - Call or write if a specific diagnosis is made (such as strep throat).
  - Tell you immediately if a diagnosis of Hib or meningococcal disease is made.
  - Keep their child home if s/he has chicken pox.
  - Keep their child home if s/he has diarrhea with illness (fever, vomiting).
  - Tell them that children need *not* stay home with mild colds, and that for most treatable infectious diseases, they can return the day after treatment has been started.
  - Call and discuss with you whether or not their child should attend when s/he has mild diarrhea.
  - Inform the center of any changes in emergency numbers where they can reached each day.

- You may want to mention other health policies or health information in this same letter.

- Be Watchful! Learn to look for signs of infectious disease. Send a note home if you suspect a problem. Unless a child is very ill, avoid sending a child home in the middle of the day -- remember, s/he has *already* exposed others by the time the problem is recognized.

- Inform staff and parents of contagious disease in the center in accordance with the guidelines provided for individual diseases discussed later in the chapter. Feel free to copy our letters, write your own, or make phone calls.

Diseases Spread through the Intestinal Tract

GENERAL PRINCIPLES

■ WHAT ARE THEY?

These diseases are caused by germs that multiply in the intestines and then are passed out of the body in the stool. Some of these germs can cause infectious diarrhea (Giardia, Shigella, Salmonella, Campylobacter). Some of them cause itching (pinworms). Others cause a "total body" illness, but are still spread from person to person through stool (Hepatitis A). These six diseases will be discussed in greater detail later in this chapter.

■ WHO GETS THEM?

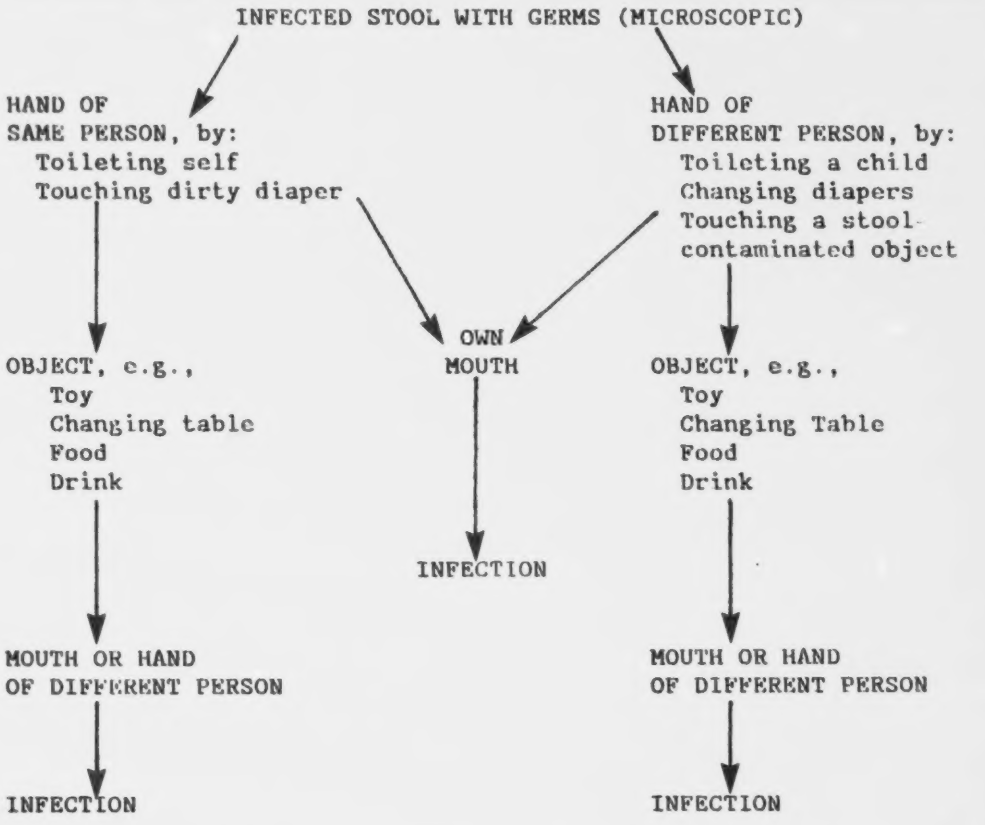
Anyone can catch the diseases that are spread in this manner. These are also diseases that you can catch over and over again (except for Hepatitis A). In day care centers, especially those with infants and children in diapers, the risk is greater because staff and children may get stool on their hands more frequently, especially during toileting/diapering.

■ HOW DO PEOPLE GET THEM?

These germs live and multiply in the intestines and are passed out of the body in the stool. The diseases spread when very small amounts of stool containing these germs get on hands or objects, and then end up unknowingly in someone else's mouth. The germs are too small to see -- you do not realize your hand has become "contaminated," since your hand will not look "dirty." If you then put your hand in your mouth or someone else's, the germs are swallowed and pass into the intestines. For some of these germs (e.g., Shigella and Giardia), swallowing as few as 10 to 100 can cause an infection; for others (e.g., Salmonella and Campylobacter), many more must be swallowed. Obviously the first kind can spread more easily.

To complicate matters, children (or staff) with these germs in their stool may not act or feel sick or have diarrhea. There is no way to tell (except by laboratory tests) if any particular stool has these germs in it or not.

These germs can also spread through objects in the environment, such as toys, tables, food, and so on. If the germs end up being smeared on an object, they can live there for hours, sometimes even days. Eventually another person touches them and they end up in a mouth. The following chart illustrates some of the ways the germs can spread from stool to another person.


INFECTED STOOL WITH GERMS (MICROSCOPIC)
HAND OF SAME PERSON, by:
Toileting self
Touching dirty diaper
HAND OF DIFFERENT PERSON, by:
Toileting a child
Changing diapers
Touching a stool-contaminated object
OWN MOUTH
INFECTION
OBJECT, e.g.,
Toy
Changing table
Food
Drink
OBJECT, e.g.,
Toy
Changing Table
Food
Drink
MOUTH OR HAND OF DIFFERENT PERSON
MOUTH OR HAND OF DIFFERENT PERSON
INFECTION
INFECTION

■ WHERE DO YOU REPORT THEM?

Parents, staff, and your health consultant should be notified if one of these diseases turns up in the center. The following infectious diseases should be reported to your local Board of Health:

- Infectious Diarrhea caused by: Amoeba, Campylobacter, Giardia, Salmonella, Shigella, Yersinia
- Hepatitis A
- Pinworms do *not* need to be reported.

STOP

SPREAD

1. HANDWASHING IS THE SINGLE MOST IMPORTANT WAY TO STOP THE SPREAD OF THESE DISEASES.

   - Children and babies should have their hands washed:
     a. after toileting/diaper changes
     b. after touching body secretions
     c. before eating/preparing food
     d. upon arrival at the center (if at all possible).

   - Adults (this includes staff, volunteers, students, and parent helpers) should wash their hands:
     a. after toileting/diapering a child or using the bathroom themselves.
     b. after handling body secretions
     c. before eating/preparing food, or feeding children.
     d. when they arrive at the center, before starting work.

2. Insist on general cleanliness at the center. (See earlier section on prevention.)

   - The diaper changing surface must be washed and disinfected after each diaper change.

   - Dirty diapers should be kept in a covered container with a plastic liner, away from food and materials used with children. Paper diapers are definitely preferable.

   - The sinks, toilets, and diaper pail must be washed and disinfected at least once a day.

   - Surfaces of toys and other objects that may be handled or mouthed by children should be washed and disinfected at least once a day.

3. To prevent the spread of infectious disease, it may be wise to separate children into groups during day care (infants, diapered children, and toilet-trained children). If this is done, each staff member should care for one group only to avoid carrying germs from group to group. However, this grouping may not necessarily be best from a child development or administrative point of view. Day care directors need to consider many factors in grouping children and assigning staff.

INFECTIOUS DIARRHEA

WHAT IS IT?

Diarrhea is:

- An increase in the number of stools over what is normal for that person
  AND
- Stools which are unformed (loose/watery and take the shape of the container they are in).

NOTE: Breast-fed babies may have stools which are *normally* unformed.

Infectious diarrhea is diarrhea caused by a virus, parasite or bacteria. It can spread quickly from person to person, especially in day care centers.

Non-infectious diarrhea can be caused by toxins (certain types of food poisoning, for example), chronic diseases (such as cystic fibrosis), or antibiotics (such as ampicillin). Non-infectious diarrhea does *not* spread from person to person.

The following causes of infectious diarrhea will be discussed in more detail in this chapter: *Giardia, Salmonella, Shigella,* and *Campylobacter.*

There are other agents that can also cause infectious diarrhea in children. These include parasites (such as cryptosporidiosis and amoeba), other bacteria (such as Yersinia), and other viruses (such as Rotavirus). Although these other disease causing organisms are not discussed in detail, the general principles outlined in this chapter are applicable to prevent the spread of *any* of these germs.

WHO GETS IT?

Anyone can catch infectious diarrhea. It can spread especially quickly among babies and young children who are not toilet-trained or who may not wash their hands well after going to the bathroom.

It can also easily spread to the adults taking care of them and helping them with diapers or toileting.

HOW DO PEOPLE GET IT?

The germs that can cause infectious diarrhea are spread from stool to mouth as described in "General Principles -- Diseases Spread Through the Intestinal Tract."

■ HOW IS IT DIAGNOSED?

The germs can be diagnosed by stool cultures or by looking at stool under a microscope for eggs or parasites. (The health care provider will ask for a stool sample and send it to a laboratory.)

■ HOW IS IT TREATED?

Treatment depends on the cause. See the sections on each infection.

■ WHEN SHOULD PEOPLE BE SENT HOME OR EXCLUDED?

- Children or staff who have diarrhea with fever or vomiting or who have severe or bloody diarrhea should be kept home until the diarrhea is gone.
- Children who have mild diarrhea and do not have fever or vomiting may come to the center if SPECIAL PRECAUTIONS are taken. SPECIAL PRECAUTIONS means that there must be *strict* enforcement of *all* handwashing, diapering, toileting, and cleaning procedures. In some cases, such precautions might include a separate room or area with added staff attention. If this cannot be done, then children with diarrhea need to be excluded until the diarrhea is gone.
- If you feel uncomfortable keeping a child with diarrhea at your center, you may choose to exclude all children with diarrhea. In this case, make sure parents are aware of your policies.
- Children and staff who may be found to have one of these germs in their stool but who are not sick and do not have diarrhea *do not have to be excluded,* although in some instances they need to be treated after a diagnosis is made. If they attend day care, it is *very important to use SPECIAL PRECAUTIONS* with their stools or diapers (careful handwashing and cleaning).
- Staff with any of these germs in their stool should not engage in food preparation or feed children at the center until two stool tests taken 48 hours apart are negative.

■ WHEN CAN THEY COME BACK?

- If children or staff *are* excluded, they may return when the diarrhea is gone and, in certain cases, after treatment has begun.

■ WHERE TO REPORT DIARRHEA?

You should report diarrhea to staff, parents, and your health consultant. You should report to your local Board of Health *if more than three* children or adults have diarrhea at the same time *or if anyone* is infected with Giardia, Salmonella, Shigella, Campylobacter, Yersinia, or Amoeba.

STOP

SPREAD

1. *Insist* on good handwashing practices and general cleanliness in the center. *Use disposable latex gloves as necessary. See page 33.*

2. Use SPECIAL PRECAUTIONS and/or EXCLUSION when necessary.

3. *Stamp out little outbreaks before they become big outbreaks.*

If One Child Has Diarrhea:
- Use SPECIAL PRECAUTIONS or EXCLUDE that child.

If Two or Three Children Have Diarrhea at the Same Time:
- Do all of the above PLUS

- Ask families of those children to take a stool sample to their health care provider to be cultured and also examined for ova (eggs) and parasites.

- Tell parents and staff that some children have diarrhea. Ask them to tell you if their child has developed diarrhea and, if so, to have the child's stool tested.

- Become even more fanatical about cleanliness, especially in diapering and toileting areas.

- Talk with your health consultant.

If More Than Three Children Have Diarrhea at the Same Time:
- Do all of the above PLUS

- Call your local Board of Health for help. You may or may not know the cause of the diarrhea at the time you call. Your local Board of Health will help you to prevent further spread of the diarrhea.

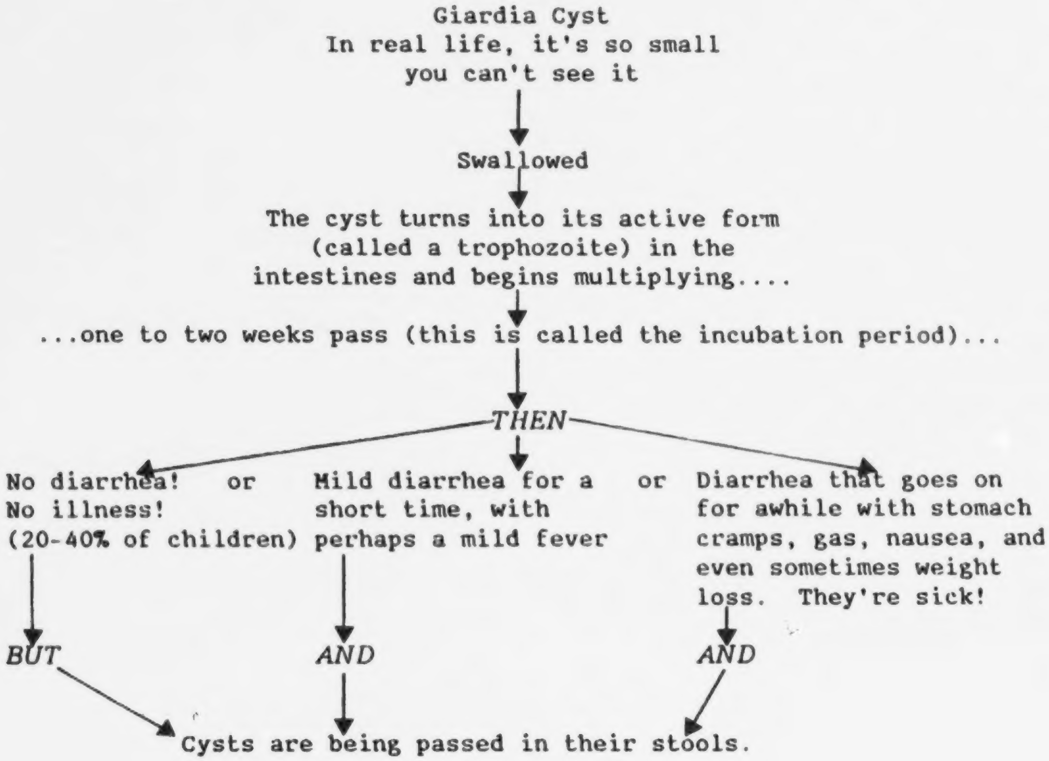
Remember to report to your local Board of Health any infection due to Amoeba, Campylobacter, Giardia, Salmonella, Shigella, or Yersinia in your center, even if you do not have an outbreak and do not need help in controlling spread.

GIARDIA LAMBLIA

WHAT IS IT?

Giardia lamblia (Giardia) is a microscopic parasite that can infect the upper part of the intestines. The infectious form of the parasite is called a cyst and is passed in the stool.

If someone becomes infected with Giardia, there are several different things that could happen. This is illustrated in the diagram below.


Giardia Cyst
In real life, it's so small you can't see it
Swallowed
The cyst turns into its active form (called a trophozoite) in the intestines and begins multiplying....
...one to two weeks pass (this is called the incubation period)...
THEN
No diarrhea! or No illness! (20-40% of children)
Mild diarrhea for a short time, with perhaps a mild fever
or
Diarrhea that goes on for awhile with stomach cramps, gas, nausea, and even sometimes weight loss. They're sick!
BUT
AND
AND
Cysts are being passed in their stools.

Untreated persons, whether or not they have diarrhea or are sick, may pass cysts in their stools off and on for several months. Therefore, they could infect other people.

WHO GETS IT?

Anyone can (and does!) catch Giardia. It is a very common infection. Surveys show between 3 and 20 percent of people have it at any one time. It is a very common infection in day care centers, especially ones that have children under age three. It spreads easily from these children to their caretakers and families.

■ HOW DO CHILDREN/ADULTS GET IT?

You can catch Giardia by swallowing as few as 10 to 100 of the microscopic cysts. Occasionally this happens by drinking cyst-contaminated water (e.g., well water). Usually, however, Giardia is spread from person to person through stool which contains cysts. It spreads quickly in day care centers, because infants and small children cannot completely toilet themselves (including good handwashing), and also normally put their hands everywhere, from their bottoms to food to other people's mouths. The cysts are very hardy and can live for long periods outside the body. This means that a toy contaminated with stool could be mouthed by another child several days later, and the second child would then become infected.

The child or adult with formed or semi-formed stool, rather than diarrhea, may be most actively spreading the parasite because this is where more cysts are found. Everyone should be very careful about handwashing and cleaning.

■ HOW IS IT DIAGNOSED?

Giardia is diagnosed by testing stool for ova and parasites, a technique in which the stool is directly examined under a microscope. Because Giardia is passed in the stools intermittently, stool specimens taken on different days may be necessary. A single test will pick up 50 to 70 percent of infections; three tests will pick up 90 percent.

■ HOW IS IT TREATED?

Most health providers agree that persons with Giardia who are ill or have diarrhea should receive one of the medications available. There is debate about whether persons with Giardia without diarrhea or illness should be treated. Because of the possibility of easy spread of Giardia in day care centers, it is recommended that all persons with Giardia in their stool be treated, regardless of symptoms. Your local Board of Health and health consultant will help you with this decision.

■ WHEN SHOULD THEY BE EXCLUDED?

• Diarrhea and sick:	EXCLUDE until treated and fever and diarrhea are gone.

• Mild diarrhea and not sick, but Giardia in stools:	SPECIAL PRECAUTIONS or EXCLUDE. Also, should receive treatment.
• No diarrhea, not sick, but Giardia in stools:	SPECIAL PRECAUTIONS with stool No need to exclude; should receive treatment.

- *Staff with a positive stool culture for Giardia should not engage in food preparation or feed children* at the center until two stool tests taken 48 hours apart are negative. The first stool test should be taken 48 hours *after* s/he has finished antibiotic medication.

■ WHEN CAN THEY COME BACK?

Excluded children/staff can come back after treatment and when severe diarrhea is gone. However, SPECIAL PRECAUTIONS should be taken with their stools until there are two negative stool tests 48 hours apart.

■ WHERE TO REPORT IT?

You are required to notify parents and staff if Giardia is diagnosed in either a child or staff member. (See Figure 43 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health. Family and household members in contact with a person with Giardia diarrhea should be made aware of their possible exposure to this parasite, *especially if they are involved in food handling or preparation.* If they develop diarrhea, they should immediately see their health care provider and get a stool test.

STOP

SPREAD

See Infectious Diarrhea, p. 277.

Figure 43
Sample Letter on Giardia

Dear Parent or Guardian:

_______ A child in our center has Giardia.

_______ Your child may have Giardia.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child and members of your family for diarrhea, stomach cramps, gas and nausea.

2.
   - If your child develops severe diarrhea or diarrhea with fever or vomiting, do not send him/her to the center.
   - If your child develops mild diarrhea, please call us to discuss whether or not s/he should come to the center.
   - *In either case, ask your health care provider to do a stool test for Giardia.* S/he will probably want to do this test also on any other person in your family who comes down with diarrhea.
   - *If* the test is positive, keep your child home until any serious diarrhea or illness is over, and your child has received medication.

3. Please keep us informed about how your child is doing and about any positive tests or treatment.

What is Giardia? Giardia is a very small (microscopic) parasite that can infect the intestines and stools. People who catch it may or may not be sick or have diarrhea. Of those who become ill, most are only mildly sick. However, some people have bad smelling diarrhea, gas, stomach cramps, lack of appetite and nausea. It may last a long time and cause weight loss. The infection, whether or not it causes symptoms, can come and go for months if not treated.

How do you catch Giardia? Giardia germs live in the intestines and are passed out of the body into the stools. (Remember, they are microscopic, so you cannot see them.) If people do not wash their hands well after going to the bathroom, changing diapers, or helping a child go to the bathroom, germs stay on their hands and the children's hands. The germs can then spread to food or drink or to objects and, eventually, to other people's hands and mouths. The germs are then swallowed by the other person or child, multiply in their intestines, and cause an infection.

Obviously it can spread easily among small children who normally get their hands into everything and may not wash their hands well.

How do you know you have it? Giardia can be diagnosed by a test called "stool for ova and parasites," in which the stool is examined under a microscope. However, because Giardia is passed in the stools off and on, several stools taken over several days may need to be examined.

What can you do to stop the spread of this germ?

- Be sure everyone washes their hands carefully *after* using the bathroom or helping a baby or child with diapers or toileting and *before* preparing or eating food. Babies and children need to have their hands washed, too, at these times.

- If someone in your family develops diarrhea, talk to your health care provider about getting a stool test. *This is critical for family or household members who handle or prepare food as a job.*

- Medication is recommended for children and adults with Giardia in their stools, as it shortens both the length of the illness and the time the germ is found in the stool. Your health care provider will decide the best medicine for you or your child.

REMEMBER: *The most important prevention is handwashing* after going to the bathroom yourself, and washing your hands as well as your child's hands after changing diapers or helping them in the bathroom.

SHIGELLA

WHAT IS IT?

Shigella is a family of bacteria; there are actually 40 different types. These bacteria can cause a diarrheal illness that can be anything from very mild to very severe. In mild cases, a person may have only watery or loose stools for a few days. In severe cases, the diarrhea may have blood and mucus and may lead to dehydration. Fever, severe cramps, vomiting, headache, and even convulsions (in young children) can occur.

Illness generally begins one to four days after accidental swallowing of the bacteria. Usually the symptoms go away on their own without treatment after four to seven days; however, bacteria may still be passed out in the stool for several more weeks.

Even though the vast majority of cases are mild, medication is usually recommended if a stool culture is positive. Treatment cuts down on the number of days of diarrhea and also cuts down on the spread of the disease. It is usually recommended in the day care setting to reduce spread.

WHO GETS IT?

Anyone can, but in the United States it is most common in children under five, and can be a significant problem in day care centers.

HOW DO YOU GET IT?

Among small children, it is spread when diarrheal stools get on hands or objects and then onto other children's hands and mouths. It takes as few as ten swallowed bacteria to cause the infection.

Remember, the bacteria are microscopic; ten bacteria could be in a piece of stool so small it couldn't be seen or smelled. Shigella can also be spread through stool-contaminated food, drink, or water. Also, remember that it can be in the stool of children or adults who are not sick and do not have diarrhea.

HOW IS IT DIAGNOSED?

Shigella is diagnosed by doing a test called a stool culture. It can take up to 72 hours to grow the bacteria from a stool sample.

HOW IS IT TREATED?

Antibiotic medication shortens both the length of the illness and the amount of time bacteria is passed out in the stool. It should be given to children and adults who are known to have Shigella in their stool.

WHEN SHOULD THEY BE EXCLUDED?

• Diarrhea and sick:	EXCLUDE until treated and fever and diarrhea are gone.
• Mild diarrhea, not sick:	SPECIAL PRECAUTIONS or EXCLUDE. Also, should receive treatment.
• No diarrhea, not sick, but Shigella in stools:	SPECIAL PRECAUTIONS with stool. Also, should receive treatment. No need to exclude.

- *Staff with positive stool cultures should not engage in food preparation or feeding children* until they have two negative stool cultures taken 48 hours apart. The first culture should be taken 48 hours *after* they have finished their antibiotic medication.

WHEN CAN THEY COME BACK?

Excluded children and staff may come back after treatment and when severe diarrhea is gone. However, SPECIAL PRECAUTIONS should be used with all persons who had a positive test for Shigella *until* they have had two negative stool tests after treatment.

WHERE TO REPORT IT?

You are required to notify parents and staff. (See Figure 44 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health. Family and household members in contact with a person with Shigella diarrhea should be made aware of their possible exposure to this bacteria, *especially if they are involved in food handling or preparation.* If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

STOP SPREAD

See Infectious Diarrhea, p. 277.

Figure 44

Sample Letter on Shigella

Dear Parent or Guardian:

______ A child in our center has Shigella.

______ Your child may have Shigella.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child and members of your family for diarrhea or stomach cramps.

2.
   - If your child develops severe diarrhea, diarrhea with blood or mucus, fever, or vomiting, do not send him/her to the center.
   - If your child develops mild diarrhea, please call us to dicuss whether or not s/he should attend the center.
   - In either case, ask your health care provider to do a stool test for Shigella. S/he will probably want to also do this test on any other person in your family who comes down with diarrhea.
   - *If* the test is positive, keep your child home until any serious diarrhea or illness is over, and your child has received medication.

3. Please keep us informed about how your child is doing, and about any positive tests or treatment.

What is Shigella? Shigella is a very small (microscopic) bacteria that can infect the intestines and stools. People who catch it may or may not be sick or have diarrhea. Of those who become ill, most are only mildly ill. However, some people have fever, stomach pain, and bloody, mucousy stools. The bacteria can continue to be passed in the stools for several weeks after the illness itself seems over.

How do you catch Shigella? Shigella germs live in the intestines and are passed out of the body in the stools. (Remember, they are microscopic - you cannot see them.) If people do not wash their hands well after going to the bathroom, changing diapers, or helping a child go to the bathroom, germs stay on their hands and the children's hands. The germs can then spread to food or drink or to objects and eventually to other people's hands and mouths. The germs are then swallowed by the other person, multiply in their intestines, and cause an infection.

Figure 44 (cont.)

How do you know you have Shigella? Shigella can be diagnosed by a test called a "stool culture." It may take 72 hours to grow the germs from the stool and identify it.

What can you do to stop the spread of this germ?

- Be sure everyone washes their hands carefully *after* using the bathroom or helping a baby or child with diapers or toileting and *before* preparing or eating food. Babies and children need to have their hands washed, too, at these times.

- If someone in your family develops diarrhea, talk with your health care provider about getting a stool test. *This is critical for family or household members who handle or prepare food as a job.*

- Medication is recommended for children and adults with Shigella in their stools, as it shortens the length of the illness and the amount of time the germ is found in the stools. Your health care provider will decide on the best medicine for you or your child.

REMEMBER: *The most important prevention is handwashing* after going to the bathroom yourself, and washing your hands as well as your child's hands after changing diapers or helping them in the bathroom.

SALMONELLA

WHAT IS IT?

Salmonella is a family of bacteria that includes over 2,000 different types. The most common illness caused by Salmonella is diarrhea accompanied by stomach cramps, pain, and fever. These symptoms usually develop within a day or two of accidentally swallowing the germs, and may go away by themselves in two to five days. However, the germs may be present in the stool for several weeks after the diarrhea is over. Very rarely, Salmonella can cause a blood stream infection or infect a part of the body (such as a joint). There may also be people who do not have diarrhea but are passing this bacteria in their stools. They are called "carriers."

WHO GETS IT?

Anyone can, but children under the age of five and adults over 70 get it most often. Salmonella is more likely to cause a severe infection in the very young, the very old, and people with underlying diseases, such as sickle cell anemia or cancer.

HOW DO PEOPLE GET IT?

In day care, Salmonella is usually spread by "stool to mouth." Small children can pass it along easily by stool going from one child's hand to an object or directly to another child's hands. A very large number of Salmonella bacteria must be swallowed to cause an illness, so Salmonella is not as big a problem in day care centers as are Giardia and Shigella.

Salmonella can be spread by contaminated food or drink. It can also be found in uncooked meat or poultry. Therefore it is very important that all foods in a day care center be thoroughly cooked (especially beef and poultry products) and any leftovers must be carefully stored (this means refrigeration!). Food preparation surfaces (tables and counters) should be carefully washed and disinfected after preparing food. Raw (unpasteurized) milk -- goat or cow -- is frequently contaminated with Salmonella and should *not* be used in a day care setting. Some years ago, outbreaks of Salmonella due to contact with small pet turtles led to laws prohibiting the sale of these animals as pets.

HOW IS IT DIAGNOSED?

Salmonella is diagnosed by doing a test called a "stool culture." It can take up to 72 hours to grow the bacteria from a stool sample.

HOW IS IT TREATED?

Medication is *not* usually given for diarrhea caused by Salmonella, because it does not shorten the illness. In fact, medication can actually lengthen the amount of time the germ is found in the stool.

WHEN SHOULD THEY BE EXCLUDED?

• Diarrhea and sick:	EXCLUDE until fever and diarrhea are gone and they are well.
• Mild diarrhea, not sick, but Salmonella in stools:	SPECIAL PRECAUTIONS with stool, or EXCLUDE.
• No diarrhea, not sick, but Salmonella in stools:	SPECIAL PRECAUTIONS with stool. No need to exclude.

- *Staff with positive stool cultures should not prepare food or feed children* until they have two negative stool cultures taken 48 hours apart. They should wash their hands carefully after going to the bathroom.

WHEN CAN THEY COME BACK?

Excluded children and staff can come back when severe diarrhea is gone and they are no longer sick. However, SPECIAL PRECAUTIONS should be taken with the stools of all persons who had a positive test for Salmonella until they have two negative tests.

WHERE TO REPORT IT?

You are required to notify parents and staff. (See Figure 45 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health. Family and household members in contact with a person with Salmonella diarrhea should be made aware of their possible exposure to this bacteria, *especially if they are involved in food handling or preparation.* If they develop diarrhea, they should immediately see their health care provider and get a stool test.

STOP

SPREAD

See Infectious Diarrhea, p. 277.

Figure 45
Sample Letter on Salmonella

Dear Parent or Guardian:

_____ A child in our center has Salmonella.

_____ Your child may have Salmonella.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child and members of your family for diarrhea or stomach cramps.

2. • If your child develops severe diarrhea or diarrhea with fever or vomiting, do not send him/her to the center.

   • If your child develops mild diarrhea, please call us to discuss whether or not s/he should come to the center.

   • *In either case, ask your health care provider to do a stool test for Salmonella.* S/he will probably want to do this test as well on any other person in your family who comes down with diarrhea.

   • If the test is positive, keep your child home until any serious diarrhea or illness is over.

3. Please keep us informed about how your child is doing, and about any positive tests.

What is Salmonella? Salmonella is a very small (microscopic) bacteria that can infect the intestines and stools. People who catch it and become ill may have only mild diarrhea, or may have severe diarrhea, painful stomach cramps, and fever. After swallowing the germs, people usually become sick within six to 72 hours. The diarrhea usually goes away on its own in two to five days. However, the germ can continue to be passed in the stools for several weeks, even after all signs of illness have disappeared.

How do you get Salmonella? Samonella germs live in the intestines and are passed out of the body into the stools. (Remember, they are microscopic - you cannot see them.) If people do not wash their hands well after going to the bathroom, changing diapers, or helping a child go to the bathroom, germs stay on their hands and the children's hands. The germs can then be spread to food or drink or to objects, and eventually to other people's hands and mouths. The germs are then swallowed by the other person or child, multiply in their intestines, and cause an infection.. Obviously Salmonella can spread among small children who normally get their hands into everything and may not wash their hands well.

How do you know you have Salmonella? Salmonella can be diagnosed by a test called a "stool culture." It may take 72 hours to grow the germ from the stool and identify it.

What can you do to stop the spread of this germ?

- Be sure everyone washes their hands carefully *after* using the bathroom or helping a baby or child with diapers or toileting, and *before* preparing or eating food. Babies and children need to have their hands washed, too, at these times.

- If someone in your family develops diarrhea, talk with your health care provider about getting a stool test. *This is critical for family or household members who handle or prepare food as a job.*

  Medication is NOT usually recommended for this infection, as it does not shorten the illness. Medication can actually lengthen the amount of time the germ is found in the stools.

REMEMBER: *The most important prevention is handwashing* after going to the bathroom yourself, and washing your hands as well as your child's hands after changing diapers or helping them in the bathroom and before touching food.

CAMPYLOBACTER

■ WHAT IS IT?

Campylobacter is a family of bacteria that can cause diarrhea. These bacteria are a common cause of diarrhea with fever in adults and children; there are occasional outbreaks in day care centers. Two to ten days after swallowing the germs, people may come down with diarrhea (which may be severe and bloody), stomach cramps, vomiting, and fever. Usually these symptoms go away on their own, in one to ten days, but there may still be germs in the stools for several weeks if treatment is not given.

■ WHO GETS IT?

Anyone can.

■ HOW DO YOU GET IT?

Campylobacter are spread "stool to mouth." The bacteria are passed out of the body in the stools. If hands are not properly washed, stool can accidentally spread to the mouth. It is necessary to swallow a large number of these bacteria to become ill, so this illness is not as easy to catch as Giardia or Shigella.

Outbreaks have occurred because of spread through water, milk or food, especially poorly cooked poultry products, unpasteurized milk, and contaminated water. Puppies and kittens who have this germ in their stools may also be a source of infection to people.

■ HOW IS IT DIAGNOSED?

Campylobacter is diagnosed by a test called a stool culture. It can take up to 72 hours or longer to grow the bacteria from a stool sample.

■ HOW IS IT TREATED?

Antibiotic therapy may not shorten illness. However, it does shorten the amount of time the germ is passed in the stools. Therefore, in the day care setting, adults and children with Campylobacter in their stools should receive medication. This will reduce the chance of spread to others.

WHEN SHOULD PEOPLE BE EXCLUDED?

• Diarrhea and sick:	EXCLUDE until fever and diarrhea are gone and they are well.
• Mild diarrhea, not sick, but Campylobacter in stools:	SPECIAL PRECAUTIONS or EXCLUDE; should receive treatment.
• No diarrhea, not sick, but Campylobacter in stools:	SPECIAL PRECAUTIONS with stool; should receive treatment. No need to exclude.

- *Staff with positive stool cultures should not prepare food or feed children* until they have two negative stool cultures taken 48 hours apart. The first culture should be taken 48 hours *after* they have finished their antibiotic medication.

WHEN CAN THEY COME BACK?

Excluded children and staff can come back after treatment and when severe diarrhea is gone. However, SPECIAL PRECAUTIONS should be taken with the stools of *all* persons who had a positive test for Campylobacter *until* they have two negative tests after being treated.

WHERE TO REPORT IT?

You must report cases of Campylobacter to parents and staff. (See Figure 46 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health. Family and household members in contact with a person with Campylobacter diarrhea should be made aware of their possible exposure to this bacteria, *especially if they are involved in food handling or preparation.* If they develop diarrhea, they should immediately see their health care provider and get a stool culture.

STOP

SPREAD

See Infectious Diarrhea, p. 277.

Figure 46
Sample Letter on Campylobacter

Dear Parent or Guardian:

_______ A child in our center has Campylobacter.

_______ Your child may have Campylobacter.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child and members of your family for diarrhea or stomach cramps.
2. - If your child develops severe diarrhea, bloody diarrhea, or diarrhea with fever or vomiting, do not send him/her to the center.
   - If your child develops mild diarrhea, please call us to discuss whether or not s/he should attend the center.
   - In either case, ask your health care provider to do a stool test for Campylobacter. (S/he will probably also want to test any other family member who comes down with diarrhea.)
   - If the test is positive, keep your child home until any serious diarrhea or illness is over, and your child has received medication.
3. Please keep us informed about how your child is doing, and about any positive tests or prescribed medications.

What is Campylobacter? Campylobacter is a very small (microscopic) bacteria that can infect the intestines and stools. People who catch it may or may not be sick or have diarrhea. Many people who catch it are only mildly ill. However, some people have severe, bloody diarrhea, fever, stomach cramps, and vomiting. The bacteria can continue to be passed in the stools for several weeks after the illness itself seems over.

How do you catch Campylobacter? Campylobacter germs live in the intestines and are passed out of the body in the stools. (Remember they are microscopic - you cannot see them). If people do not wash their hands well after going to the bathroom, changing diapers, or helping a child go to the bathroom, germs stay on their hands and the children's hands. The germs can then be spread to food and drink or to objects and, eventually, to other people's hands and mouths. The germs are then swallowed by the other person or child, multiply in their intestines, and cause an infection.

How do you know you have Campylobacter? Campylobacter can be diagnosed by a test called a "stool culture." It may take 72 hours or longer to grow the germ from the stool and identify it.

What can you do to stop the spread of this germ?

- Be sure everyone washes their hands carefully *after* using the bathroom or helping a baby or child with diapers or toileting and *before* preparing or eating food. Babies and children need to have their hands washed, too, at these times.

- If someone in your family develops diarrhea, talk with your health care providers about getting a stool culture. *This is critical for family or household members who handle or prepare food as a job.*

- Medication is usually recommended for children and adults with Campylobacter in their stools, as it shortens the length of time the bacteria is passed out in the stools, although it does not shorten the duration of the diarrhea. Your health care provider will decide on the best medicine for you or your child.

REMEMBER: *The most important prevention is handwashing* after going to the bathroom yourself, and washing your hands as well as your child's hands after changing diapers or helping him/her in the bathroom and before touching food.

PINWORMS

WHAT ARE THEY?

Pinworms are tiny worms that only infect people. These worms live in the lower intestine. At night the female worms, which resemble short, white threads less than half an inch long, come out through the anus and lay their microscopic eggs around the opening. In some people, this causes intense itching; in others, nothing. Pinworms do not cause teeth grinding or bedwetting as some people believe. They are not dangerous, just irritating.

WHO GETS THEM?

Anyone can. Some estimates are that 5 to 15 percent of people in the United States have pinworms at any one time; in other countries, the rate is even higher. It is particularly common in preschool and school-aged children and thus in day care centers. Often, members of an infected child's household are also unknowingly infected and, if not treated, can reinfect a treated child.

HOW DO YOU CATCH THEM?

When a child (or adult) scratches his or her itchy bottom, the microscopic eggs can come off onto the fingers or under the fingernails. The children may then put their fingers into someone's mouth or into food, and that someone swallows the eggs which hatch into worms in the intestines. People can also keep reinfecting themselves by swallowing eggs that are on their own hands. The eggs can also be indirectly spread through contact with clothing or bedding that has been contaminated with eggs. In general, it is easy to become infected and reinfected.

HOW ARE THEY DIAGNOSED?

A health care provider can make the diagnosis by asking the parent to apply the sticky side of transparent tape around the anal area so any eggs on the skin will stick to it. This is best done first thing in the morning before bathing. The tape is then placed sticky side down on a slide and examined under a microscope to see if there are any eggs.

HOW ARE THEY TREATED?

There are several medicines available to treat this infection. Often the health care provider will treat the whole family if one person in the home is infected. The treatment may be repeated in two weeks.

SHOULD PEOPLE BE EXCLUDED?

No. Children (and adults) do NOT need to be excluded from the center for a pinworm infection. These infections are not dangerous, although they can be a nuisance.

WHERE TO REPORT IT?

Parents and staff should be notified so they may watch for symptoms in themselves and/or their children. (See Figure 47 for a sample letter to parents.)

STOP SPREAD

1. Handwashing and general cleanliness in the center as previously outlined are the most important preventive measures.
2. Every child should have his/her own crib or mat and should not switch sheets. Mats should be kept clean.
3. Each child's dirty clothing should be stored separately in plastic bags and sent home for laundering.

Figure 47

Sample Letter on Pinworms

Dear Parent or Guardian:

______ A child in our center has pinworms.

______ Your child may have pinworms.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Check your child for pinworms.
2. If you think your child may have pinworms, call your health care provider to find out how to test for them.
3. If your child does have pinworms, please tell us at the center.

What are pinworms? Pinworms are small, white, thread-like worms that live in the large intestine and only infect people. The female worms crawl out through the anus at night and lay eggs on the skin around the opening. This can cause intense itching in this area. It does *not* cause teeth grinding or bedwetting as some people mistakenly believe. It is not a dangerous disease, just a very irritating one.

Who can get pinworms? Anyone can. If a child gets them, other family members often will also.

How do you catch pinworms? When children scratch their bottoms, the eggs get on their hands and under their fingernails. The children may then touch someone else's mouth, food, or a toy or table. Someone else may get the egg on his or her hands and eventually swallow it. The egg hatches inside the body. It is very easy to spread pinworms around and to catch them over and over.

What do you do about pinworms? The doctor or nurse will ask you to place sticky tape on your child's bottom first thing in the morning and will then look at the tape under the microscope. If there are pinworm eggs on the tape, he or she will give your child a medication which cures the infection. S/he may also treat your whole family because other people in households are often infected as well but are not aware of it.

REMEMBER: Always wash your hands and your child's hands carefully before eating or preparing food and after going to the bathroom.

HEPATITIS A

WHAT IS IT?

Hepatitis A is an infection of the liver caused by the Hepatitis A virus. Although the virus causes a total body illness, it is spread through the intestines and stools. After the virus is swallowed, it is often two to eight weeks before illness begins. Adults often suffer from tiredness, loss of appetite, nausea, fever, and jaundice (yellowing of the skin and whites of the eyes as well as dark brown urine). These symptoms usually last from one to two weeks, though some adults may be sick for several months. Most young children who catch the virus do not become sick at all, or have only a mild flu-like illness without jaundice.

WHO GETS IT?

Anyone can. It can spread especially quickly in groups of small children who are not yet toilet-trained and who cannot wash their own hands well. Because most young children with Hepatitis A do not become ill, often the first sign of the infection in a day care center is a jaundiced parent or staff member.

HOW DO THEY GET IT?

Hepatitis A virus is passed out of the body in the stool and is spread by the "stool to mouth" method, just like infectious diarrheal diseases. The virus is not found in urine, saliva, or other body fluids. It is found only briefly in the blood. A person is most contagious during the two weeks before the illness begins. This is when there are the *most* virus particles in the stool. Usually, within a week after the illness starts, the virus disappears from the stool.

Contact with stool-contaminated food, drink, or environmental surfaces can also spread the infection, just as with contagious diarrheal diseases.

HOW IS IT DIAGNOSED?

Hepatitis A is diagnosed by a special blood test that tells you if you have ever caught the infection, whether or not you were sick with it.

HOW IS IT TREATED?

There is no treatment that cures Hepatitis A. However, because the incubation period (the time between swallowing the virus and getting sick) is so long, it is possible to prevent the illness by giving a protective shot of immune globulin within two weeks of exposure.

■ WHEN SHOULD PEOPLE BE EXCLUDED?

Staff or children who are jaundiced and anyone exposed to Hepatitis A within the last two weeks who has not received immune globulin should be excluded. Persons exposed to Hepatitis A who do not receive immune globulin should be excluded for six weeks after the last case occurs.

■ WHEN CAN THEY COME BACK?

People who are sick with Hepatitis A can return to the center one week after the illness started AND when their fever is gone. People who were exposed to someone with Hepatitis A can return after they receive a protective shot of immune globulin.

■ WHERE TO REPORT IT?

Parents and staff must be notified. (See Figure 48 for a sample letter to parents.) You should also notify your health consultant and the local Board of Health.

STOP SPREAD

1. The most important prevention is strict enforcement of handwashing and cleanliness rules (see General Principles).

2. Make sure all parents and staff notify the center if any person in their household is diagnosed with Hepatitis A.

3. If a household member comes down with Hepatitis A, the child or staff member living there should get a blood test to see if s/he has the illness as well. If the test is negative, s/he should receive a shot of immune globulin. If the test is positive for Hepatitis A, continue as outlined below.

4. You may have an outbreak if, in the course of one month:
   - One day care child OR one staff person develops Hepatitis A (diagnosed by blood test or illness)
     or
   - People with Hepatitis A are found in two or more households of day care children or staff.

5. At this point, call your local Board of Health. They will help you investigate the possible outbreak and will also request that exposed children and adults be given the immune globulin shot by their own health care providers. (The immune globulin can be obtained free of charge from the Department of Public Health upon request of the local Board of Health or a physician.)

6. When a case of Heptatitis A occurs in a center which has children in diapers, all children and staff should get the shot. If there are no children in diapers, only staff and children in the infected person's class need to get the shot.

7. If an outbreak of Hepatitis A occurs in a center, all children enrolled or staff hired during the six weeks following the last case of Hepatitis A should receive immune globulin before coming to the center in order to prevent further spread of the disease.

Figure 48
Sample Letter on Hepatitis A

Dear Parent or Guardian:

A child or staff member in our center has been diagnosed with a viral infection called Hepatitis A, and your child may have been exposed.

What is it? Hepatitis A is an infection of the liver caused by a virus. It can cause tiredness, fever, lack of appetite, nausea, and jaundice (yellowing of the skin and whites of the eyes, with darkening of the urine). The illness usually lasts one to two weeks. Young children do not usually become jaundiced, however, and may have a "flu-like" illness, or nothing at all.

How do you get it? The virus lives in the intestines and is passed out of the body in the stools. The virus is microscopic so you cannot see it. If people do not wash their hands well after toileting a child or themselves, or wash the child's hands, the virus can be spread to other people, food, drink, or other things. The germs can then be swallowed by another person, multiply in the intestines, and cause illness two to eight weeks later. If a person is exposed (that is to say, may have swallowed some germs), the illness may be prevented by a shot of immune globulin.

How is it diagnosed? Hepatitis A is diagnosed by a blood test.

What can you do?

1. Be sure everyone in your household washes their hands after going to the toilet, helping a child go to the toilet, or changing a diaper. They must wash the children's hands, too. *This is the most important thing to do!* Hands should also be washed before touching food, eating, or feeding.

2. If anyone in your household develops signs of Hepatitis A, ask your health care provider to do a blood test and tell us if it is positive.

Also, do any of the items below which are checked off:

______ Your child needs to receive a shot of immune globulin from your health care provider. (The immune globulin is available free of charge to your physician from the Department of Public Health.)

______ Other people in your household need the shot as well. See your health care provider.

Diseases Spread Through the Respiratory Tract

GENERAL PRINCIPLES

WHAT ARE THEY?

This is a varied group of diseases that all spread through infectious droplets of nose, eye, or throat secretions. They can cause mild common illnesses, such as viral "colds" and strep throat, and also life-threatening diseases, such as bacterial meningitis.

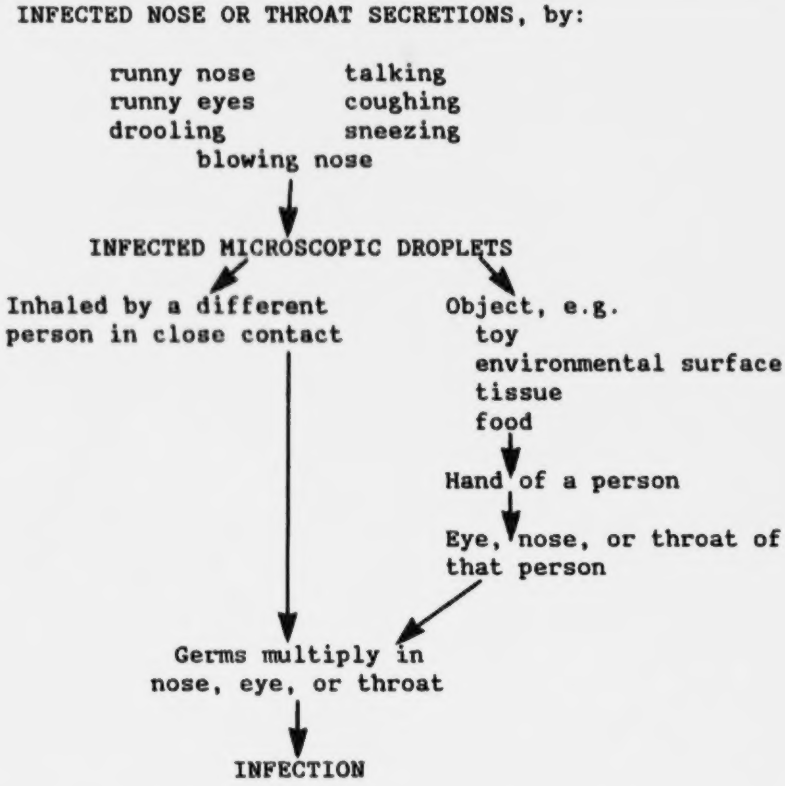
WHO GETS THEM?

Some of these diseases, such as Hib *(Haemophilus influenzae* type B) infections, are most common in children; others, like the common viral "cold," seem to affect all ages fairly equally. Because young children often do not wash their hands after they wipe their noses or eyes, and are in constant physical (and oral!) contact with objects around them, these types of diseases spread easily in a day care setting.

HOW DO THEY GET THEM?

Germs in droplets from the nose or throat spread when an infected person talks, coughs, sneezes, or blows his/her nose. These droplets can be breathed in when another person is in close contact with an infected person. The germ can then multiply in the nose and throat and cause infection. The droplets can also land on an object (such as a hand, a toy, or food), which another person then touches, and brings in contact with his/her nose, eyes, or mouth, allowing the germ to multiply and cause infection. The chart on the following page illustrates this.

Infectious droplets are often produced *before* the person has symptoms of infection -- during the "incubation period" of the illness. Some of these germs can also remain sometimes for periods of time in the nose and throat of someone who is not ill, but can still infect other people through the spread of infectious droplets. Such a person is referred to as a "carrier," or is said to "carry" the disease or germ.


INFECTED NOSE OR THROAT SECRETIONS, by:
runny nose
runny eyes
drooling
talking
coughing
sneezing
blowing nose
INFECTED MICROSCOPIC DROPLETS
Inhaled by a different person in close contact
Object, e.g.
toy
environmental surface
tissue
food
Hand of a person
Eye, nose, or throat of that person
Germs multiply in nose, eye, or throat
INFECTION

STOP SPREAD

1. General principles of handwashing and cleanliness in the center are essential (see section on Prevention). Especially important are:
   a. Staff and children should wash their hands after wiping or blowing noses; after contact with any nose, throat, or eye secretions; and before preparing or eating food.
   b. Mouthed toys should be washed and disinfected at least once daily, as should frequently used surfaces (such as tables).
   c. Eating utensils should be carefully washed in hot, soapy water (dishwasher is best), disinfected, and air-dried.
   d. Disposable cups should be used. If this is not possible, each child should have his/her own cup, which no one else ever uses. These cups must be washed in hot, soapy water after each use, not merely rinsed out.
   e. The center should have fresh air and be aired out completely once a day, even in the winter.

2. Children and staff should learn to cough or sneeze toward the floor or to one side. If they sneeze or cough into a hand or tissue, they must properly dispose of the tissue and wash their hands. (See #5 below.)

3. Runny noses and eyes should be promptly wiped; wash hands afterwards.

4. Disposable towels/tissues should be used.

5. Towels/tissues contaminated with nose, throat, or eye secretions should be disposed of in a covered container with a plastic liner, and kept away from food and materials used in child care.

Common Illnesses

RESPIRATORY VIRAL ILLNESSES - ("COLDS," INFLUENZA, AND ROSEOLA)

WHAT ARE THEY?

Colds are mild infections of the nose and throat which are very common in young children (and in the adults who are around them!). They are caused by many different viruses. (The most frequent kind is a rhinovirus.) Usually the viral illness causes some combination of stuffy nose, runny nose, sore throat, cough, runny eyes, ear fluid, fever, and the "blahs."

Influenza is also caused by a virus (e.g., *Influenza* A or B) and causes symptoms of high fever, congestion, cough, and muscle ache. Most people with influenza feel too ill to attend day care. *Roseola* is another viral infection, which starts as a high fever (103° F or above), which generally lasts for three to four days; few other symptoms are seen. Soon after the fever has ended, the child develops a lacy-like rash which appears over the whole body at once. At this point, the child feels well.

There are no medicines or treatments which cure these viral illnesses, but there are many medicines which claim to make the sufferer more comfortable. Occasionally, a viral "cold" can be complicated by a second, bacterial infection, such as an ear infection, sinus infection, or pneumonia; these complications can be treated with appropriate antibiotics.

The remainder of this section applies to all of the above viral illnesses. For simplicity, we will refer to them as "colds."

■ WHO GETS THEM?

Anyone can! Young children in general catch many colds per year; they catch a few more if they have young siblings or attend day care than if they are an only child at home. As the number of persons in contact with a child increases, so does the likelihood of exposure to the common viruses that cause colds!

Often, children and adults may have such a mild cold that no one is ever aware they are sick. However, they are still contagious.

■ HOW DO THEY GET THEM?

The viruses can only grow in live cells, but they can be transmitted from one person to another in respiratory secretions (i.e., tears, saliva, airborne nose discharge, phlegm). Infected droplets may be scattered through sneezing or coughing or they may land on surfaces touched by other persons, who then touch their eyes, nose, or mouth.

Viral shedding into respiratory secretions is usually highest two to three days *before* a person develops symptoms of illness, and then for three to five days after. Thus, by the time a child or staff member shows the symptoms of an illness, the virus has already spread.

■ HOW ARE THEY DIAGNOSED?

Although these viruses can be grown in special cultures in the laboratory, this is time-consuming, expensive, and most of the time, unnecessary. These illnesses are usually diagnosed by their symptoms.

■ HOW ARE THEY TREATED?

Most health care providers suggest rest and plenty of fluids, since there is no real treatment. Occasionally, a decongestant medicine may be used. A child who has a high fever, persistent cough, or earache should be evaluated by a health care provider to see if there is a bacterial infection on top of the viral infection that requires antibiotics. Because of a possible association with Reye's Syndrome (vomiting, liver problems, and coma), aspirin (salicylate)-containing products should NOT be used for fever control if influenza is suspected.

■ SHOULD PEOPLE BE EXCLUDED?

Other than for influenza, there is no reason to exclude children or staff with these viral illnesses, if they feel well enough to attend. It would serve no purpose since by the time they have symptoms, everyone else has already been exposed. Persons with influenza will generally feel too ill to attend or work.

WHERE TO REPORT THEM?

There is no need to report colds or roseola, since they are not serious infections. If the center has a number of children or staff with influenza-like illness at the same time, your health consultant and local Board of Health should be notified.

STOP SPREAD

1. Children and staff should wash their hands after wiping/blowing noses.

2. Children and staff should learn to cough or sneeze toward the floor or to one side. If they sneeze or cough into a hand or tissue, they must properly dispose of the tissue and wash their hands.

3. Runny noses and eyes should be promptly wiped; then wash hands.

4. Disposable towels/tissue should be used.

5. Mouthed toys and frequently used surfaces (tables, etc.) should be washed and disinfected at least once daily.

6. The center should have fresh air and be aired out completely once a day, even in winter.

GROUP A STREPTOCOCCAL INFECTIONS ("STREP THROAT," SCARLET FEVER)

WHAT ARE THEY?

Group A Streptococci are bacteria that can cause a variety of illnesses, the most common of which are strep throat, scarlet fever, and impetigo (see section on impetigo).

Strep throat is a sore throat caused by this bacteria. The vast majority of sore throats in both children and adults are caused by cold viruses, NOT strep bacteria. Strep sore throats tend to be accompanied by fever, tender swollen neck glands, headache, and stomach ache, but can also occur with cough, runny nose, or other cold symptoms.

Scarlet fever is a form of strep infection where the bacteria produce a substance which causes a skin rash. The rash is usually red with fine bumps that feel sandpapery, and is most noticeable on the neck, chest, groin, or on the inner surface of the knees, thighs, and elbows. The rash does not usually involve the face, but cheeks are flushed and there is paleness around the mouth. The tongue may be reddish and look like the surface of a strawberry. The rash may only last a few hours. Scarlet fever is no more serious than strep throat.

Treatment of strep infections with antibiotics may not dramatically change the length or severity of the sore throat symptoms or rash. However, such treatment is *very* important. Strep is treated to prevent both its spread and the development of rheumatic fever.

Rheumatic fever (abnormalities of the heart valves and inflammation of the joints) is very rare in the United States today, but can develop five to six weeks after any type of untreated strep infection. In rare instances, kidney disease can also occur following a strep infection.

WHO GETS THEM?

Anyone can get strep throat, but it is uncommon in children under three years of age (as is rheumatic fever). It is most common in school-aged children, in the cold months, and in crowded situations (schools, the military -- and, you guessed it! -- day care centers). Often if one person in a family gets it, others do also, especially brothers and sisters.

HOW DO YOU GET THEM?

During infections, strep is in nose and mouth secretions so it can be coughed, sneezed or smeared around on hands, dishes, food, toys, and similar objects. The incubation period is two to five days; unlike colds, children are probably not infectious during this incubation period. Children are most likely to pass strep around when they have symptoms and until they have been on treatment for 24 hours.

■ HOW ARE THEY DIAGNOSED?

The diagnosis of strep throat is best made by a throat culture. It usually takes 24 to 48 hours to grow the bacteria. There are several recently developed rapid tests which can diagnose a strep infection in less time. These tests are still being evaluated.

■ HOW ARE THEY TREATED?

Strep infections are treated with an oral antibiotic for ten days. Occasionally a health care provider may give a single long-lasting injection. Depending on the symptoms, the health care provider may give antibiotics immediately or wait for the throat culture results.

■ WHEN SHOULD PEOPLE BE EXCLUDED?

1. Children who have a positive culture or test for strep infection should stay home and have twenty-four hours of medicine before returning.

2. A child who is only mildly ill, for whom the doctor has done a throat culture but did not feel was ill enough to begin antibiotics, can be allowed to continue to attend the center while awaiting the results of the culture. If the culture is positive, follow the procedure in (1) above.

Decisions on whether to send a child home in the middle of the day depend on how ill the child is and what care the center can provide for mildly ill children.

■ WHEN SHOULD THEY COME BACK?

Children who are sick or have a positive throat culture can come back when they feel better and have had twenty-four hours worth of medicine. The center will have to make sure that every dose of the medicine needed during day care hours is taken for the next ten days.

■ WHERE TO REPORT THEM?

Let all parents know if a child at the center has a strep infection. (See Figure 49 for a sample letter to parents.)

STOP

SPREAD

1. Enforce handwashing and general cleanliness in the center. If a case of strep has been diagnosed, it is particularly important to remember that:
   a. Staff and children should wash their hands after wiping/blowing noses, and before eating or preparing food.

   b. Toys and surfaces should be washed and disinfected daily.

   c. Each child should have his/her own cup; preferably, disposable cups should be used.

   d. Food should not be shared.

   e. All eating utensils should be carefully washed in hot, soapy water, disinfected, and air-dried. A dishwasher is best.

2. Keep children's noses clean and dry; wash hands.

3. Teach children to cough/sneeze to one side toward the floor or into a tissue. If they use a tissue, they need to wash their hands afterward.

4. If there is a case of strep in the center, children/staff who develop sore throat symptoms should be seen by their health care providers to be tested for strep. Generally, children/staff who do *not* have symptoms do not need to be cultured.

5. If the center experiences an outbreak, particularly if there are any cases of rheumatic fever or kidney disease associated with the outbreak, it may be advisable to culture all children and staff, and treat anyone with a positive culture once. Talk to your health consultant.

Figure 49
Sample Letter on Strep Throat

Dear Parent or Guardian:

______A child in the center has strep throat.

______Your child may have strep throat.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child for signs of a sore throat and other signs of strep (headache, fever, stomach ache, swollen and tender neck glands).

2. If your child develops a sore throat and any of these other signs, please see your health care provider. Tell your doctor or nurse practitioner that another child in the center has strep, and ask to have your child tested for strep throat.

What is strep throat? Strep throat is a sore throat caused by the streptococcus bacteria. (Most sore throats, however, are caused by viruses and are not treated with antibiotics.) The strep germs are passed around through nose and mouth secretions.

How do I find out if my child has strep throat? If your child has a sore throat and other signs of strep, your health care provider will do a throat culture or a rapid test. In one to two days, you will have the results of the culture. If strep is found, your child will receive treatment.

Why is it important that my child receive treatment? There are three reasons:

1. If not treated or not treated long enough, your child may continue to spread the infection to other members of your family or to other children in the center. Treatment reduces spread.

2. Rarely, some children with this illness later develop rheumatic fever (abnormalities of the heart valves and inflammation of the joints); treatment with antibiotics can usually prevent this.

3. Treatment will also prevent other rare, but possibly dangerous, complications.

Who gets strep throat? Anyone can. It is very common in preschool and school-aged children.

When can my child come back to the center? After taking medicine for twenty-four hours.

Figure 49 (cont.)

How can you prevent the spread of strep?

1. Wash your hands and your child's hands after wiping noses and before eating or preparing food.
2. Dishes should be washed carefully in hot soapy water or a dishwasher.
3. Children should not share cups, spoons, etc.
4. Toys that get put in the mouth should not be shared. Sharing of food should be discouraged.

CHICKENPOX (AND SHINGLES)

■ WHAT IS IT?

Chickenpox is a very contagious disease caused by the varicella-zoster virus. It usually begins with a mild fever and an itchy rash. The rash starts with crops of small red bumps on the stomach or back and spreads to the face and limbs. The red bumps rapidly become blistered, oozy, and then crust over. People may have only a few bumps or may be totally covered.

Once a person has had chickenpox and has been infected with the varicella-zoster virus, the virus stays without symptoms in the body's nerve cells. In some people (for unknown reasons), the virus can become active again at some later time, as "shingles" or zoster. Symptoms include a red, painful, itchy, blistery rash, usually in a line along one side of the body. There is no fever. The virus is shed in the blisters of the rash and can cause chickenpox in a person who has not had it, if that person has *direct* contact with the infected shingles blisters.

■ WHO GETS IT?

Anyone who is exposed to chickenpox and has not had it before will almost certainly get it! If you have had chickenpox once, you cannot get it again. It is most common in school-aged children. Shingles is most common in adults, as a person must have already had chickenpox to develop shingles.

Chickenpox is generally not a serious disease in otherwise healthy people. Adults and persons on immune-suppressor medicines (e.g., persons with cancer) tend to have more severe disease.

■ HOW DO THEY GET IT?

Chickenpox is contagious from two days *before* the rash appears until the last blister has developed crusts. It is spread by close contact (sharing breathing space or direct touching contact) with infected secretions from the nose, throat, or rash. It takes about 10 to 21 days after exposure for a person to develop the symptoms of chickenpox.

■ HOW IS IT DIAGNOSED?

Chickenpox and shingles are usually diagnosed by the typical appearance of the rash.

HOW IS IT TREATED?

There is no specific treatment for chickenpox itself. The symptoms may be treated, however, with anti-itching medicine and lotions, fever control, fluids, and rest. Because of a possible association with Reye's Syndrome (vomiting, liver problems, and coma), aspirin (salicylate)-containing products should NOT be used for fever control. Scratching should be avoided because it can cause scarring which would otherwise not occur.

A vaccine to prevent chickenpox may be available within the next five years.

WHEN SHOULD PEOPLE BE EXCLUDED?

Because of their age and behavior, children in a day care setting are highly susceptible to chickenpox. Children/staff with chickenpox should be excluded for one week after the rash first appears or until all blisters are crusted over and dry.

An adult or child with shingles sheds the virus that causes chickenpox and could cause an outbreak of chickenpox in the center. Therefore, unless the shingles rash can be completely covered, it is advisable that an adult/child with shingles stay home until the rash is crusted over and dry. The person with shingles must be very careful about personal hygiene.

WHERE TO REPORT IT?

For chickenpox, you are required to notify parents and staff. (See Figure 50 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health. Shingles does not need to be reported.

STOP SPREAD

1. The center should have a system so that it is notified if a child or staff member develops chickenpox or shingles.

2. A person with chickenpox (or shingles with a rash that cannot be completely covered) should not return until the rash is completely dry and crusted.

3. The center should watch closely for early symptoms in other children for three weeks following the most recent case. If a child or staff member develops a suspicious rash, s/he should be sent to his/her health care provider so the rash can be diagnosed. However, chickenpox is highly contagious, and in spite of your best efforts, you will probably have several more cases if children haven't already had the disease.

Figure 50
Sample Letter on Chickenpox

Dear Parent/Guardian:

______ A child/staff member in our center has chickenpox.

______ Your child may have chickenpox.

What is it? Chickenpox is a very contagious infection caused by a virus. It usually begins with a mild fever and an itchy rash. The rash starts as crops of small, red bumps which become blistery, oozy, and then crust over.

How is it spread? It is spread through exposure to infected fluids from the nose, throat, or skin rash of someone with chickenpox. This can occur either by sharing breathing space or by directly touching the infected fluids. Chickenpox is contagious from two days *before* the rash starts until all the rash is dried and crusted. After exposure, it takes ten days to three weeks before the rash appears.

How is it treated? Chickenpox is generally not a serious disease and there is no specific treatment for it. The symptoms can be treated with plenty of fluids, rest, fever control, and anti-itching medicines and lotions.

ASPIRIN (SALICYLATE)-CONTAINING PRODUCTS SHOULD NOT BE USED FOR FEVER CONTROL IN CHILDREN WITH CHICKENPOX. This is because there is a possible association between the use of aspirin and a rare but very serious disease called Reye's Syndrome (vomiting associated with liver problems and coma).

WHAT SHOULD YOU DO?

1. Watch your child for the next ten days to three weeks for the chickenpox rash.

2. If your child develops a suspicious rash, do not send him/her to the center. Your health care provider can diagnose chickenpox and give you anti-itching medicine or lotions for your child.

3. If your child develops chickenpox, s/he can return to the center one week after the rash begins or when all the blisters are dried up and crusted over.

4. If one of your children develops chickenpox, other people in the family who have not had it will probably get it, too. Chickenpox is *very* easily spread.

Serious Illnesses

MENINGOCOCCAL ILLNESSES

■ WHAT ARE THEY?

Meningococcal illnesses are caused by a bacteria called *Neisseria meningitidis* and are serious, sometimes fatal illnesses. The most common illness is *meningitis*, an infection of the coverings of the brain. Meningitis caused by *Neisseria meningitidis* must be treated immediately with hospitalization and IV (intravenous) antibiotics or the person may die. The disease usually starts suddenly with fever, chills, lethargy (a feeling of tiredness), and a rash with fine red "freckles" or purple splotches (which is caused by areas of bleeding under the skin). With meningitis, older children and adults may complain of severe headache, neck pain, and neck stiffness. In younger children, unusual irritability, poor feeding, excessive and high-pitched crying, vomiting, and fever may be seen.

■ WHO GETS IT?

This disease occurs most frequently in children under 5 years old, and especially in babies 6-12 months old, though it may occur at any age. Adults may also catch the disease.

■ HOW DO THEY GET IT?

The bacteria is passed from person to person when they are in very close contact. It is spread through infected droplets of respiratory tract secretions (sneezing, coughing, nasal discharge, saliva). It can also be passed if infected secretions are touched by people who then put their hands in their nose, eyes, or mouth. However, the bacteria cannot live on environmental surfaces -- they quickly shrivel and die. People can carry the germs, without knowing it, in their noses, mouths or throats without ever getting sick themselves; this is called "carrying" the germ or being a "carrier." The germs can be spread from carriers to other people who may then develop a meningococcal illness. Obviously, sick people can also pass the germs on. The time from exposure to illness can be from one to ten days, but is usually one to four days. After one infection has occurred in a center, there are then more than the usual number of people "carrying" the germ, so the risk of spread and serious disease becomes greater.

HOW IS IT DIAGNOSED?

These infections are diagnosed by culturing a sick person's blood or spinal fluid. It may take up to 72 hours to grow and identify the bacteria. Sometimes a doctor can make an earlier diagnosis by looking at the spinal fluid under the microscope.

HOW IS IT TREATED?

People sick with these infections require hospitalization for treatment. The "carriage" of this bacteria in the nose and throat can be greatly decreased, and many times eliminated, when a person takes a medicine by mouth called Rifampin (occasionally, a sulfa type medicine may be substituted). Both the sick person and contacts of that person (see #4 under "Stop Spread" below) should take this medicine to lower or eliminate "carriage" of the bacteria and, therefore, to lower the risk of the spread of the disease to others. (*NOTE:* Rifampin should not be given to pregnant women or persons with liver disease.)

WHEN SHOULD PEOPLE BE EXCLUDED?

Children with meningococcal disease are too ill to attend day care. Close contacts should be excluded until treatment with Rifampin is started.

WHEN CAN THEY COME BACK?

An ill person cannot come back until s/he is well (after hospital treatment) and *after* s/he has taken Rifampin for two days. Contacts may not return until they have started Rifampin.

WHERE TO REPORT IT?

All parents and staff must be notified *immediately*. (See Figure 51 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health.

STOP SPREAD

1. Your center *must* have worked out a system so that you will find out when a child or staff member comes down with a meningococcal illness.

2. Notify all staff and parents/guardians *immediately* so that they can contact their health care providers.

3. Notify your local Board of Health.

4. All close contacts of the ill person, including people in the family/household and in the classroom/day care, should take Rifampin for two days. If children are separated into classes and don't mix during the day, only the day care classmates and staff in the ill person's class need to take the medicine. The medicine should be started as soon as possible. Speak with your health consultant and/or local Board of Health if you have questions about who is a close contact.

5. Parents and staff need to be aware that Rifampin does NOT give absolute protection against disease. *Therefore, any child or adult who develops symptoms such as fever or headache requires prompt evaluation by a health care provider.*

6. Monitor the situation closely for two to three weeks. Make sure all ill children are seen by their doctors and that you are notified if another person develops meningococcal disease.

Figure 51

Sample Letter on Meningococcal Illnesses

Dear Parent/Guardian:

A child or staff member in our center has a serious infectious illness caused by a bacteria named *Neisseria meningitidis*. This bacteria can spread from person to person who share breathing space or are in close physical contact. There is a medicine called Rifampin which can be taken to reduce the risk of infection in people in close contact with the ill person.

______ Your child has been in close contact (same classroom or shared activities) with this child/staff person.

______ Your child has not been in close contact with the ill person.

WHAT SHOULD YOU DO?

1. *Call your doctor or nurse practitioner* and tell them your child is at a center where another child/staff person has come down with a meningococcal illness. Tell them whether or not your child has been in close contact.

2. *If your child has had close contact,* get a prescription for RIFAMPIN for your child unless there is a medical reason not to. Rifampin can help eliminate the germ from someone who has been exposed.

   If your child has had close contact, s/he should not come back to the center until Rifampin has been started.

3. For the next three weeks, watch your child for signs of illness or a fever. *If your child becomes ill, take him/her to a doctor immediately,* whether or not Rifampin was given, because the medicine is not always 100 percent effective. *N. meningitidis* usually causes meningitis, an infection of the coverings of the brain, which is often fatal if not treated with antibiotics.

The center will be very watchful over the next three weeks and will inform you if anyone else becomes ill.

HAEMOPHILUS INFLUENZAE TYPE B ILLNESS (Hib DISEASE)

WHAT IS IT?

Haemophilus influenzae type B (Hib) is a bacteria that causes serious, sometimes fatal illnesses, most often in young children. Some of the diseases it can cause are:

- meningitis, infection of the coverings of the brain
- epiglottitis, infection of the upper throat and entrance to the windpipe
- cellulitis, infection of the deep skin, especially of the face and neck
- arthritis, infection and swelling of the joints
- pneumonia, infection of the lung
- blood stream infections

WHO GETS IT?

These illnesses are primarily seen in children under five years of age. Epiglottitis occurs most commonly in children three to five years old, while the other diseases are most common in children under two years. Children in a day care setting may be at a slightly increased risk of catching these illnesses than children not in day care. Rarely, older children and adults may develop infection.

Like meningococcal infections, Hib disease requires relatively close contact to spread from person to person. Spread is more likely among children under four, with the highest risk in children under two. It appears that in a setting such as a household or day care center, where there are young children and everyone is in close contact, there is an increased risk of a second infection following a first case.

HOW DO THEY GET IT?

The bacteria is passed from person to person by breathing in infected droplets of nose or throat fluids scattered in the air or by direct contact with these infected secretions. The bacteria cannot live on environmental surfaces.

Like meningococcus, some people can "carry" this bacteria in their nose or throat for a period of time without it causing illness. However, a "carrier" may spread the bacteria to another person who may then become ill. In a household or day care center in which an Hib infection has occurred, the number of persons with nose or throat "carriage" is greatly increased; thus, risk of serious disease is also increased.

HOW IS IT DIAGNOSED?

These illnesses are diagnosed by culturing an infected person's blood, spinal fluid or other infected fluid. It may take up to 72 hours to grow and identify the bacteria. Sometimes a doctor can make an early diagnosis by looking at the infected fluid under the microscope.

HOW IS IT TREATED?

People sick with these infections generally require hospitalization for treatment. The "carriage" of this bacteria in the nose and throat of healthy children and adults may be reduced and perhaps eliminated when a person takes a medicine called Rifampin by mouth. In order to reduce the risk of spread within a household, both the sick person and other people living in the same house should take this medicine.

There is disagreement among authorities about the effectiveness of Rifampin in *preventing* the spread of Hib in a day care setting. There is also disagreement as to whether Rifampin, if used to prevent spread, should be taken by children after a single case of Hib disease at the center or after two cases. *There is agreement that Rifampin is unlikely to effectively prevent spread unless all children and staff in the classroom take the medicine;* otherwise the bacteria can be brought back into the center by a carrier who did not take the medicine. You and your health consultant should decide on a policy for Rifampin use and notify parents of the center's requirements *prior* to an actual infection.

There is a recently licensed vaccine to prevent Hib infections. This vaccine is recommended for all children from 18 months to five years old, particularly those in day care. Although it is not one of the vaccines currently required for children in day care, it is strongly recommended. This vaccine should be given as part of regular health care visits. The vaccine takes two weeks to take full effect. Therefore, it is not effective in preventing Hib in someone who has already been exposed or in preventing the immediate spread of Hib.

WHEN SHOULD PEOPLE BE EXCLUDED?

Children or staff who are ill with Hib disease should be excluded while they are ill and until they have taken Rifampin for four days. Based on the policy which your center has decided upon for *preventive* Rifampin use (after one or two cases in the center), children who do not receive the Rifampin as required should be excluded.

■ WHEN CAN THEY COME BACK?

Children with Hib illness should not return until they are well and *after* they have finished taking Rifampin for four days.

The center should, with its health consultant, decide if all children and staff should be required to take Rifampin after one case or after two cases of Hib disease occur in the center.

■ WHERE TO REPORT IT?

All parents and staff must be notified *immediately.* (See Figure 52 for a sample letter to parents.) You should also notify your health consultant and your local Board of Health.

STOP
SPREAD

1. Your center *must* have a system so that you will find out when a child or staff member develops a Hib illness.
2. The center should have a policy regarding Rifampin use. Children less than two years old are at greatest risk of catching serious Hib illness.
3. If an Hib infection occurs, notify all staff and parents or guardians *immediately* so they can contact their health care providers.
4. Notify your local Board of Health.
5. *Parents and staff need to be aware that Rifampin does not give 100 percent protection against disease. Therefore, any child or adult who becomes ill should be seen promptly by a health care provider.*
6. The time of greatest risk of others becoming ill is the first week following the first case, but some risk exists for up to one month. *Make sure all ill children are seen by their doctors and that you are notified if another person develops Hib infection.*

The center should encourage all attending children between 18 months and five years of age to receive the Hib vaccine, and should suggest it (perhaps on the center's Health and Immunization record form) for all children as they turn 24 months old. Local physicians and publicly-funded clinics have received information about the new Hib vaccine from the Division of Communicable Disease Control; consult your health consultant for further advice.

Figure 52
Sample Letter on Hib Disease

Dear Parent or Guardian:

A child in our center has a serious infectious illness caused by a bacteria named *Haemophilus influenzae*, type B. A short way of writing the name is Hib. Hib spreads from person to person either by sharing breathing space or by being in close physical contact. It is not at all related to the regular flu.

______ Your child has been in close contact (same classroom or shared activities) with this child/staff person.

______ Your child has not been in close contact with the ill person.

Hib can cause very serious illnesses such as meningitis (infection of the coverings of the brain), pneumonia, arthritis, epiglottitis (infection of the upper throat), blood infections, and skin infections, all of which need hospital treatment and intravenous antibiotics. Because this bacteria can spread from child to child in a center, and because it can cause serious illness, we want to make you aware of the fact that your child may have been exposed.

[Insert a statement of your center's recommendations and policy regarding the use of Rifampin to reduce the risk of spread.]

WHAT SHOULD YOU DO?

1. *Call your health care provider* and tell him or her that your child is at a center where another child has come down with an illness caused by *Haemophilus influenzae*, type B (Hib). Tell him or her whether your child has been in close contact and the center's policy on Hib.
2. Watch your child for signs of illness or a fever. *If your child becomes ill, take him/her to your health care provider.* Watch carefully for a month, but especially carefully in the next week.

The center will also be very watchful over the next month. If another child comes down with this illness, we will notify you.

TUBERCULOSIS (TB)

■ WHAT IS IT?

Tuberculosis (TB) is caused by a bacteria called *Mycobacterium tuberculosis* that infects people, and usually causes an infection of the lungs. Transmission of the germ can occur when TB germs that have been coughed into the air are inhaled by someone who shares close breathing space -- usually over a prolonged period of time -- with an infected person. Except under unusual circumstances, TB is not highly contagious, and generally requires prolonged or intense exposure to cause infection.

In more than 90 percent of people, after the TB germ is inhaled, the body's defense (immune) system will prevent *infection* with the TB germ from developing into the *disease* tuberculosis. The defense system is usually not able to kill all the germs, but is able to wall them up in tiny, hard capsules (the "tubercules" of tuberculosis) and, therefore, they do not cause illness.

Infection with the TB germ *without* disease is indicated by a positive tuberculin skin test (such as a Tine test or Mantoux test) in a person who does not have symptoms of TB, and who has a normal chest x-ray. This type of infection is *not* contagious from person to person, and has no effect on how a person feels. However, if the defense system becomes weakened due to other health problems at some time in the future, these walled-up germs could begin to multiply, "break out" of the capsules, and cause disease. Most cases of TB in the United States are caused by such "reactivation" of old TB infection. A special anti-TB medicine can be taken to prevent an infected person from "breaking down" with TB. This medicine is taken once daily for a year to kill walled-up germs that are not doing any damage, but could 'break out" years later.

TB *disease* usually affects the lungs causing cough, infected sputum, fever, weight loss, and an abnormal chest x-ray. More rarely, the TB germ can cause disease in other body organs. Persons with TB disease in areas other than the lung are usually not contagious to others, because the TB germ must be in the air and inhaled in order to cause infection in another person.

■ WHO GETS IT?

Anyone who shares breathing space with a person with active TB lung *disease,* usually over a long period of time, can develop TB *infection*; only a few of those infected, however, will develop TB *disease.* Infants, young children, and persons with problems of the immune system, are more likely to develop serious TB disease if infected.

■ HOW DO THEY GET IT?

The germ is spread into the air in tiny droplets from the nose, mouth or lung fluid of people with active lung disease when they cough, sneeze or spit. These germs can then be breathed in by someone who shares close breathing space -- usually over a prolonged period of time -- with an infected person. TB is *not* spread by brief contact in large, spacious areas, or by handling a diseased person's bed sheets, books, furniture, or eating utensils.

The TB germ is spread only from a person with active TB disease, usually in the lungs, to another person. Not all cases of TB disease are equally contagious. Advanced TB of the lung with extensive lung damage (as shown on a chest x-ray) is more often accompanied by a wet cough and is thus much more contagious than lung disease with few x-ray findings and little cough. Infants and children with TB disease are usually not very contagious. This is because there are usually fewer TB germs present in the lungs, and children are less likely to have symptoms such as a wet cough, which could spread the germ into the air.

■ HOW IS IT DIAGNOSED?

Infection with the TB germ is diagnosed by a tuberculin skin test (a Tine or Mantoux test). A test is called positive when there is a significant amount of swelling at the skin test site 48 to 72 hours after the test was placed. It may take two to three months for the skin test to become positive after first breathing in the germ. A positive skin test indicates exposure to the TB germ at some time in the past, causing the body to develop a response of the defense system to contain the germ. A positive test does not indicate if a person has TB *disease.* Further evaluation by chest x-ray and medical examination is used to determine if infection has been contained by the person's defense system or has progressed to active disease. If a person has a positive skin test AND symptoms (such as cough and fever), additional studies such as TB sputum cultures may also be done. The TB germ grows very slowly, and it can take up to three months before a culture shows growth of the germ.

■ HOW IS IT TREATED?

TB is readily treated with medicine. If a person is ill with active TB disease, several medications are taken for nine to eighteen months. These medications usually make the person non-contagious within a few weeks. TB infection without disease (that is, a positive skin test only) can be prevented from progressing to disease by taking a single medicine daily for a year.

■ WHEN SHOULD PEOPLE BE EXCLUDED?

Anyone who has been diagnosed as having active TB *disease* should not attend or work in day care.

Children who have only a positive TB skin test (with a normal chest x-ray and no symptoms of disease) are NOT contagious and should not be excluded. They usually do take preventive medicine to prevent the rare possibility of later developing active disease.

■ WHEN CAN THEY COME BACK?

Children and staff with TB disease may return after they have begun treatment and their health care provider states that they are not contagious.

■ WHERE TO REPORT IT?

TB disease must be reported to your local Board of Health. TB *infection* (positive skin test without symptoms and a normal chest x-ray) does not need to be reported. All staff, parents, and your health care consultant should be notified if a case of active TB disease occurs in your center. The local Board of Health, in conjunction with the TB Program of the Department of Public Health, will help you to notify parents and will conduct an evaluation of exposed persons, including free TB skin testing. Medical evaluation and treatment of persons suspected to have TB infection or disease is available free to the public at thirty TB clinics sponsored by the Department of Public Health throughout the state.

STOP
SPREAD

1. An adult with TB lung disease, particularly if associated with extensive lung damage on chest x-ray and wet cough, can present a significant risk to children and other adults. Therefore, it is recommended that ALL adult staff (paid or volunteer) receive a Mantoux skin test before they start to work. (Current OFC regulations *require* such pre-employment tests only for *paid* staff.) Persons with positive skin tests should receive an appropriate evaluation and medical clearance from their health care provider before beginning work.

2. Routine screening for TB is not currently required for children in day care. You may wish to require a TB skin test for newly entering children as part of their entrance physical examination, particularly if you are located in an area where the rate of TB disease is higher than average. Your local Board of Health can give you information about the TB rate in your area.

3. If a child or staff member is diagnosed with active TB, an evaluation of exposed persons will be done by your local Board of Health, in conjunction with the TB Program of the Department of Public Health. This evaluation would include TB skin testing of the center attendees and staff, and medical evaluation of anyone with a positive skin test. The skin test needs to be repeated two to three months later as it may take several months to turn positive after the person is first exposed to the TB germ.

Diseases Spread Through Direct Contact

SUPERFICIAL INFECTIONS/SKIN INFECTIONS

GENERAL PRINCIPLES

■ WHAT ARE THEY?

This group of diseases consists of superficial bacterial or viral infections and parasitic infestations. These diseases are, in general, common and not serious. They include impetigo, ringworm, conjunctivitis ("pink eye"), scabies, and head lice.

■ WHO GETS THEM?

Anyone who has direct contact with infected secretions, infected skin areas, or infested articles can develop these diseases/infestations. Because young children are constantly touching their surroundings and the persons around them, these infections are easily spread among children (and their caregivers!) in a day care center.

■ HOW DO THEY GET THEM?

They are spread by touching the infected area on another person's skin or, occasionally, by touching an object that is contaminated with infected secretions or parasites. These diseases do not spread from person to person unless there is *direct* contact with infected material.

Here are some examples of direct contact spread:

- A child has oozy sores on his arm. While playing with another child, he rubs his arm against hers. Some ooze gets on her arm and then into a cut or scratch on *her* skin.
- A child with head lice takes off his hat. There is a louse in it. Another child puts the hat on and the louse climbs onto the second child's head.
- A child has runny eyes. She rubs them with her hand, then puts her hand on a toy. Another child then touches the toy, gets eye discharge on his hand, then rubs his eyes, putting the eye discharge from the first child into his own eyes.

STOP SPREAD

1. Handwashing and cleanliness in the center are the most important ways to prevent spread. Especially important are the following:

a. Make sure staff and children wash their hands after contact with any possible infectious secretions.

b. Use free-flowing water for handwashing, not basins or stoppered sinks, which can become contaminated with the germs.

c. Liquid soap dispensers are preferable to bar soap.

d. Always use disposable tissues or towels for wiping and washing.

e. Never use the same tissue or towel for more than one child.

f. Dispose of used tissues and paper towels in a lined, covered container which is kept away from food and child care materials.

g. Toys should be washed and disinfected at least daily, and frequently used surfaces (tables, counters, furniture, floors) in the center should be washed or vacuumed daily.

2. Each child should have his/her own crib or mat and should not switch. Sheets and mats should be kept clean and stored so that the sleeping surfaces do not touch each other.

3. Children should not be allowed to share personal items such as combs, brushes, blankets, pillows, hats, or clothing.

4. Each child's dirty clothing should be stored separately in plastic bags and sent home for laundering. It should not be laundered at the center.

5. Sores, cuts, or scrapes should be promptly washed and covered; eyes should be wiped dry.

6. Rashes, sores, running eyes, and severe itching should be reported to the parent so that a health care provider can be seen, if necessary.

IMPETIGO

WHAT IS IT?

Impetigo is a very common skin infection caused by Streptococcal or Staphylococcal bacteria. It may start as oozing at a injured spot on the skin (such as an insect bite, cut, or burn). It can easily be spread by the person's hands to other areas of the skin. In children, the face is often involved. The rash looks oozy, red, and round and may have a flat, honey-colored crust. The area may be itchy. The Staph bacteria can cause blisters which break easily and leave raw, red, oozy skin exposed. Impetigo caused by the Strep bacteria can be associated in very rare circumstances with the development of a kidney disease. Impetigo is most commonly seen in the warm summer months.

WHO GETS IT?

Ordinarily the skin protects the body from bacteria. When the skin is broken (cut, scraped, bitten, scratched), bacteria can get under the surface, multiply, and cause an infection. Children, who touch everything and wash only under duress, are likely to have multiple cuts and scrapes on their bodies at all times which make them more vulnerable to impetigo than adults. Most children have impetigo at least a few times during their growing-up years; adults can get it, too!

HOW DO THEY GET IT?

The bacteria are under, on, and in the infected skin, and they are shed into the secretions ("ooze"), and crusts. They can be spread to another person who directly touches the infected skin, or a surface contaminated by the ooze or crusts. If the bacteria then get under the top protective skin layer of the second person, they multiply and cause infection.

HOW IS IT DIAGNOSED?

Most of the time, impetigo can be diagnosed by the way it looks. Bacterial cultures are not usually needed. Strep and staph impetigo may look the same, though staph tends to cause blisters more often.

HOW IS IT TREATED?

Usually some combination of a special soap, antibiotic ointment, and an oral antibiotic is given.

■ SHOULD PEOPLE BE EXCLUDED OR SENT HOME?

The child does not need to be sent home in the middle of the day if a suspected impetigo rash is noticed. Wash the area with soap and water and cover it. *Wash your hands and the child's afterwards.* Notify the parents when they come to pick up the child and tell them that the child should be seen by a health care provider.

■ WHEN CAN THEY COME BACK?

Children/staff can come back after taking medicine for twenty-four hours. The sores should be kept lightly covered until they have dried up.

■ WHERE TO REPORT IT?

Parents and staff should be told. (See Figure 53 for a sample letter to parents.)

STOP SPREAD

1. If children hurt themselves and cause a break in the skin, wash the area thoroughly with soap and water, and dry carefully.
2. If you think a child may have impetigo:
   a. Wash the rash with soap and water and cover it loosely with gauze, a bandage, or clothing.
   b. Be sure anyone who touches the rash washes his/her hands well.
   c. Dispose of any soiled tissues/bandages carefully; keep any dirty clothing in a plastic bag and give to the parent for laundering at home.
   d. Ask the parents to have the child seen by their health care provider.

Figure 53
Sample Letter on Impetigo

Dear Parent and Guardian:

______ A child in our center has impetigo.

______ Your child may have impetigo.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

- Check your child's skin for an impetigo rash.
- Take your child to your health care provider if you suspect your child has an impetigo rash so that medicine may be prescribed.
- Tell us if your child was treated for impetigo.
- If your child has impetigo, s/he may return after taking medicine for 24 hours.

What is impetigo? Impetigo is a skin infection common in young children. It mostly is seen on the face and around the mouth, but can occur any place on the skin.

What does it look like? The skin is red and may be oozing. There may be small bumps clustered together or larger red areas. These areas may have honey-colored crusts or blisters. It spreads quickly. It is often itchy. Children may scratch the crusts off and cause a little bleeding.

What causes impetigo? Impetigo is caused by common skin germs (like strep and staph). These germs usually only cause infection when the skin is injured (scraped, cut, scratched, etc.). It can spread easily among small children who touch everything and is therefore very common among this age group.

How is impetigo diagnosed and treated? Your health care provider can tell you if your child has impetigo. Usually it is treated with some combination of a special soap, antibiotic ointment, and an oral antibiotic.

The most important thing is to keep the impetigo rash *clean* and *dry*. You may want to cover it lightly so the ooze and crusts cannot be spread to other people. Anybody who does touch the rash should wash his/her hands very well.

RINGWORM (TINEA)

WHAT IS IT?

Ringworm, also known as tinea, is a mild infection of the skin or nails caused by several different fungi. *These infections are not serious and are easily treated.*

On the *skin*, ringworm appears as a flat, growing, ring-shaped rash. The edges of the circle are usually reddish and may be raised, scaly, and itchy; the center of the circle is often clear. Another type of fungus can cause the skin to become lighter in flat patches, especally on the trunk and face. On the *scalp*, infection begins as a small bump and spreads outwards, leaving scaly patches of temporary hair loss (infected hair is brittle and breaks off easily). On the *feet*, the skin between the toes scales and cracks, and blisters may be seen. On the *nails*, a chronic infection causes thickening, discoloration, and brittleness of the nails.

WHO GETS IT?

Anyone can! It spreads easily.

HOW DO THEY GET IT?

Ringworm is spread by infected skin touching healthy skin or by broken nails or skin flakes full of fungus falling onto objects in the environment (such as floors, hair scissors, or clothes) which are touched later by other people.

HOW IS IT DIAGNOSED?

These infections can often be diagnosed by their typical appearance. Occasionally, scrapings of suspicious skin may be examined under the microscope or cultured to see if a ringworm fungus is present.

HOW IS IT TREATED?

Most often, an antifungal medicine in an ointment is applied to the skin for several weeks. Occasionally, an antifungal medicine is taken by mouth, particularly if the diagnosis is ringworm of the scalp.

SHOULD PEOPLE BE EXCLUDED OR SENT HOME?

There is no need to exclude children/staff with these common, mild infections after treatment is started. A person with a suspicious rash should be referred to a health care provider for appropriate diagnosis and treatment. It is *NOT* necessary to send him or her home in the middle of the day. They can come to the center the same day treatment is started.

WHERE TO REPORT IT?

Parents and staff should know if more than one person at the center develops one of these infections. (See Figure 54 for a sample letter to parents.) There is no need to report these infections anywhere else.

STOP SPREAD

1. As previously outlined, handwashing and general cleanliness at the center are important.

2. Children should not share personal items (such as combs), cribs, mats, or clothing.

3. Each child's dirty clothing should be stored separately and sent home for laundering.

4. The center should be kept clean, dry, and cool. Fungi grow more easily on moist, warm surfaces.

5. If infection is suspected:

    a. Ask parents to have their child seen by their health care provider.

    b. Loosely cover the affected area with gauze, bandage, or clothing to prevent shedding of infected scales.

    c. Be sure cleaning procedures are being followed.

Figure 54
Sample Letter on Ringworm

Dear Parent or Guardian:

______ A child in the center has ringworm.

______ Your child may have ringworm.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Check your child for ringworm.
2. Take your child to your health care provider if you think s/he has ringworm.
3. Tell the center if your child has ringworm.

What is ringworm? Ringworm is a rash caused by a fungus. *It is not dangerous, and it can be treated easily.* It does spread easily.

What does the rash look like? On the body you often see red rings that are slightly raised, itchy, and scaly. On the scalp you may see circles of hair loss. On the feet you may see cracking and peeling between the toes. Another kind causes whitish patches on the face or body.

How do you catch ringworm? Ringworm is spread by touching the rash on another person or touching scales or broken hairs which have fallen off the rash.

How do you know if your child has it? Your health care provider can tell you by looking at the rash. Sometimes other tests are needed.

When can my child come back? Children can return to the center the same day treatment (usually an ointment) is started.

CONJUNCTIVITIS (PINK EYE)

WHAT IS IT?

Conjunctivitis is an infection of the eyes commonly known as "pink eye." It is most often caused by a virus (like colds) but can also be caused by bacteria. The white parts of the eyes become pink or even hurt, and the eyes run (lots of tears and discharge). In the mornings, the discharge (which is pus) may make the eyelids stick together. (Some children and adults have allergies, which can cause everything listed above *except* pus.) Conjunctivitis is a mild illness. Viral conjunctivitis will go away by itself in one to three weeks.

WHO GETS IT?

Anyone can get it, but preschoolers and school-age children have it most often, and can spread it to people taking care of them or to each other.

HOW DO THEY GET IT?

People get conjunctivitis by getting some "pink eye" pus into their own eyes. Children often pass it along by rubbing their eyes and getting discharge on their hands and then:

- touching another child's eyes.
- touching another child's hands. The second child then touches his eyes.
- touching an object. Another child touches the object and then puts her hands to her eyes.

It can also be passed along by staff washing, drying, or wiping a child's face and then using the same washcloth/towel/paper towel/tissue on another child's face. Staff could also get eye discharge on their hands when wiping a child's eyes and then pass it along as outlined above.

HOW IS IT DIAGNOSED AND TREATED?

Symptoms of conjunctivitis are obvious; however, it is often difficult to tell if the cause is bacterial or viral. Occasionally the doctor will examine the discharge under the microscope or culture it. Often an antibiotic eye medicine will be given because treatment of bacterial conjunctivitis shortens the length of symptoms and decreases infectiousness. There is no treatment for viral conjunctivitis; it will go away by itself but may last a week or more. It is recommended that children in a day care setting with conjunctivitis be treated with antibiotic eye medicine in order to prevent as much spread as possible.

SHOULD THEY BE EXCLUDED OR SENT HOME?

Conjunctivitis is a mild illness, and children with conjunctivitis noticed in day care do not need to be sent home in the middle of the day. Let parents know that the symptoms were noticed.

WHEN CAN THEY COME BACK?

Infected persons may come back the day after treatment is begun. If the health care provider decides not to prescribe a medicine, a note should also be sent in.

WHERE TO REPORT IT?

Parents and staff should be notified. (See Figure 55 for a sample letter to parents.)

STOP SPREAD

1. Follow handwashing and center cleanliness guidelines previously outlined.
2. Keep children's eyes wiped free of discharge.
3. Always use disposable tissues/towels for wiping and washing. NEVER use the same tissue/towel for more than one child.
4. *Always wash your hands after wiping a child's eyes.*
5. Dispose of tissues/towels in a lined, covered container kept away from food and child care materials.
6. Teach children to wash their hands after wiping their eyes.
7. Be sure articles that may touch children's eyes (binoculars, prisms, toy cameras, etc.), are washed well with soap and water at least once daily.

Figure 55
Sample Letter on Conjunctivitis

Dear Parent or Guardian:

______ A child in our center has conjunctivitis ("pink eye").

______ Your child may have conjunctivitis.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch your child and members of your family for "pink eye."
2. If your child develops pink eye, see your health care provider. Your child may need an eye medication.
3. Do not send your child to the center until the day after you start giving the medicine. If your health care provider decides not to prescribe an eye medicine, s/he should give you a note to send in with your child.
4. Tell us at the center if your child is being treated for pink eye.

What is conjunctivitis? Conjunctivitis is an infection of the eyes, commonly known as pink eye. It is most often caused by a virus (like colds) but can also be caused by a bacteria. The white parts of the eyes become pink or red, the eyes may hurt, feel itchy or scratchy, and they may produce lots of tears and discharge. In the mornings, the discharge (which is pus) may make the eyelids stick together. (Some children and adults have allergies which can cause everything listed above *except* pus.)

Conjunctivitis is a mild illness. It is NOT dangerous. Doctors usually prescribe an antibiotic eye medication just in case it is due to bacteria.

How do you catch conjunctivitis? The discharge from the eye (the pus) is infectious. If children rub their eyes, they get it on their hands. They can then touch someone's eyes or hands or touch an object (toy or table). If other children get discharge on their hands and then touch their own eyes, they can catch it. It can spread easily among small children who touch their eyes and everything else and who do not know how (or forget) to wash their hands.

What can you do if your child has conjunctivitis?

1. Keep your child's eyes wiped free of discharge. Use paper tissues, then throw them away promptly.
2. *Always wash your hands after wiping your child's eyes.*
3. Teach your child to wash his/her hands after wiping his/her eyes.
4. Ask your health care provider if your child needs to receive eye medicine.
5. Be sure to carefully wash anything that touches your child's eyes (such as washcloths, towels, toy binoculars, and toy cameras).

SCABIES

■ WHAT IS IT?

Scabies is a common skin infection caused by a microscopic parasite called a mite; this mite is found only on people. The female mite burrows under the skin to lay her eggs, which hatch and start the infestation cycle again. The average number of mites per patient is usually only ten to twelve.

Symptoms of scabies do not appear until two to six weeks after exposure; the skin reaction is probably due, in part, to a sensitization or "allergic" reaction to the mites. On re-exposure, symptoms can start within days. The infestation is in the form of an intensely itchy rash, which consists of red bumps and burrows (short, wavy, dirty-looking lines in the skin). Due to the vigorous scratching caused by the itching, scratch marks may cover up the typical appearance of the rash. The areas most commonly involved are the sides of the fingers and finger-webs, wrists, elbows, underarms, and belt lines. However, in infants, the head, neck, palms, soles, and buttocks may also be involved.

■ WHO GETS IT?

Anyone who has contact with the mite can become infested with scabies.

■ HOW DO THEY GET IT?

The mite is spread by direct skin-to-skin contact, or by skin contact with clothes, bedding, etc., that the mites have crawled onto. The mites can survive only three days off the body, and cannot jump or fly. They require direct contact with skin to be spread.

■ HOW IS IT DIAGNOSED?

It can be diagnosed by the typical appearance of the rash and accompanying symptoms and by examining skin scrapings under the microscope to see the mite or its eggs.

■ HOW IS IT TREATED?

It is treated with one of several prescription mite-killing creams or lotions which are applied once to the skin, and then washed off after a specified period of time. Medicine to relieve the itching is often necessary. (*NOTE*: even after effective therapy, itching can persist for up to two to four weeks.) Some doctors may treat all household members (even those without symptoms) once, due to the high likelihood of spread within a household.

■ SHOULD PEOPLE BE EXCLUDED OR SENT HOME?

If a rash suspicious of scabies is noticed in day care, tell the parents the child should be seen by a health care provider (see Sample Letter). It is not necessary to send the child home in the middle of the day. Staff should take extra precautions regarding cleanliness.

■ WHEN CAN THEY COME BACK?

An infested person can return the day after treatment is started.

■ WHERE TO REPORT IT?

Parents and staff should be notified. (See Figure 56 for a sample letter to parents.)

STOP SPREAD

1. Follow previously outlined principles of handwashing and cleanliness at the center.
2. Children should not share personal items, cribs, mats, or clothing.
3. Each child's dirty clothing should be stored separately and sent home for laundering.
4. If a case of scabies occurs in the center:
   - Wash and dry on the hot cycle all washable items belonging to the center that came into contact with the child's skin during the 72 hours prior to treatment.
   - Difficult-to-wash items (such as stuffed toys and pillows) can be stored in tightly closed plastic bags for four days and then used again. (The mite cannot live off the body for more than three days.)
   - Thoroughly vacuum any carpet or upholstered furniture.
5. If the center experiences a large number of cases of scabies among children/staff, it may be necessary to treat all children and caregivers in the group once. Talk with your health consultant if you think you have a major problem with scabies.
6. Pesticide sprays are not recommended and can be harmful to people and animals.

Figure 56

Sample Letter on Scabies

Dear Parent or Guardian:

_____ A child in our center has scabies.

_____ Your child may have scabies.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Watch for signs of an itchy rash (usually in lines) over the next two to six weeks.

2. If a rash develops, see your health care provider.

3. Tell us at the center that your child has scabies.

What is scabies? Scabies is a common skin rash caused by microscopic animals called mites which are found only on people. The mite digs under the skin and lays eggs which then hatch. The new mites dig more paths and lay more eggs. The rash appears as red bumps and short, wavy lines in the skin (where the mites have dug). It is especially common between fingers and toes and at the wrist and ankle, but can occur anywhere. The rash is intensely itchy. Scabies is not dangerous, but it is very annoying.

Who can get scabies? Anyone can.

How do you get scabies? You catch it from another person who has it or from clothes or bedding used by a person with scabies. The mites cannot jump or fly, but they can crawl. They can live for three days off the body.

If my child has scabies, what should I do?

1. See your health care provider to get medicine to treat the scabies.

2. Wash in hot water all clothes, hats, sheets, pillow cases, blankets, towels, etc., that your child has used. Dry on the hottest setting on the dryer.

3. If there are things you do not want to wash (pillows, blankets, toys, stuffed animals), put them in tightly closed plastic bags for four days.

4. Thoroughly vacuum all carpets and upholstered furniture. Pesticide sprays are not recommended; they can be harmful to people and animals.

When can my child go back to the center if s/he has scabies? The day after receiving treatment. (Sometimes your doctor may want to treat the whole family because scabies can spread so easily.)

Remember: Scabies is annoying but not dangerous.

PEDICULOSIS (HEAD LICE)

■ WHAT IS IT?

Head lice are tiny insects that live only on people's scalps and hair. They hatch from small eggs, called nits, which are attached to the individual hairs near the scalp. These nits are firmly attached to the hair and cannot be easily moved up or down the hair (as could specks of dandruff). Nits may be found throughout the hair, but are most often located at the back of the scalp, behind the ears, and the top of the head. The eggs hatch in about ten days, with new lice reaching adulthood in about two weeks. The female louse is about the size of a sesame seed, can live for 20 to 30 days, and can lay about six eggs a day. The lice live by biting and sucking blood from the scalp. Lice can survive up to eight hours between feedings and can do so off the body.

The major symptom of head lice is itching caused by the bite of the louse. Persistent scratching of the head and back of the neck should be viewed with suspicion. Often red bite marks and scratch marks can be seen on the scalp and neck, and a secondary bacterial infection can occur causing oozing or crusting. Swollen neck glands can also occur.

■ WHO GETS IT?

Head lice are not a sign of unclean people or homes. They can occur at any age and to either sex. Anyone who has close contact with an infested person or shares personal items can become infested.

■ HOW DO THEY GET IT?

Lice do NOT jump or fly. They cannot be caught from grass, trees, or animals. They are spread only by crawling from person to person directly or onto shared personal items, such as combs, brushes, head coverings, clothing, bedding, towels, etc. Frequent bathing or shampooing will NOT prevent lice or eliminate them once they are established.

■ HOW IS IT DIAGNOSED?

Lice are less than one-eighth inch long and are usually light brown. They move quickly and avoid light, making it difficult to see them. Diagnosis is more often made by finding *nits*. Nits are tiny, pearl-grey, oval-shaped specks attached to the hair near the scalp. It helps to use a magnifying glass and natural light when searching for them. The best places to look are the hair on the back of the neck, behind the ears, and the top of the head.

■ HOW IS IT TREATED?

Treatment is directed at getting rid of the lice from both the infested person and his/her surroundings and personal items. All household members and persons with close physical contact should be examined for lice and treated if infested. Some health care providers may simultaneously treat all members of a household once.

Treating the Infested Person

There are several medicines to treat head lice. They are used like shampoo. Kwell Shampoo* and Prioderm Lotion* are available by prescription only. Other products such as RID*, R&C Shampoo*, XXX*, and A-200 Pyrinate* are available over-the-counter.

All of these products must be used carefully. It is especially important to consult a physician before treating (1) infants, (2) pregnant or nursing women, or (3) anyone with extensive cuts or scratches on the head or neck.

Although these products will kill lice, none will kill 100 percent of the nits. Nit removal after shampooing may be time-consuming and difficult due to their firm grip on the hair. A solution of vinegar and water may help make removal easier. There are special, fine-tooth combs manufactured to aid in nit removal. A daily nit check for the next ten days is advisable. If there is evidence of new nits (less than one-fourth inch from the scalp) or newly hatched lice, it may be necessary to repeat treatment. *Unless reinfestation occurs, repeated treatments are unnecessary and can be dangerous.*

Treating the Surroundings/Personal Items in the Day Care Center

1. Machine wash in *hot* water all washable items belonging to the center that may contain lice. Dry in a *hot* dryer.

2. Nonwashables (such as furry toys and pillows) can be put in a *hot* dryer for 20 minutes or dry-cleaned.

3. Things which cannot be washed or dried can be sealed in a plastic bag for 30 days, the life cycle of the louse.

4. Combs, brushes, etc., can be boiled for ten minutes, or soaked in 2 percent Lysol and water or a bleach and water solution (1/4 cup bleach in one gallon water) for one hour.

---

*Brand names are mentioned for identification purposes only and are not an endorsement. Other similar products may also be used.

5. Rugs, upholstered furniture, and mattresses should be carefully vacuumed.

6. *Insecticide sprays are not recommended and can be harmful to people and animals.*

SHOULD THEY BE EXCLUDED OR SENT HOME?

A child found to have an active case of head lice should be kept separate from other children and the parents notified that the child may not return the next day unless treated. Other close contacts should be checked at the same time to determine if there are other cases as well. If a center is having a problem with head lice, morning "head checks" before the children mingle together may be necessary.

WHEN CAN THEY RETURN?

There is some disagreement among authorities about whether to require complete nit removal after treatment before allowing a child to return to school or day care. Removal of nits is difficult, and the majority of nits will be killed by treatment. However, reinfestation is possible if some nits survive and hatch into adult lice. The center staff and health consultant should decide on the best policy for both the center and the parents. Regardless of the policy, to ensure successful treatment the children need to be checked for new nits for ten days after therapy.

WHERE TO REPORT IT

Parents and staff should be notified. (See Figure 57 for a sample letter to parents.)

STOP SPREAD

1. General cleanliness at the center, as previously outlined, should be practiced.

2. Children should not share personal items such as clothing, brushes, combs, hats, etc.

3. Each child should have his/her own crib or mat and should not switch.

4. Children's personal belongings should be stored separately.

5. Caregivers should learn to recognize nits and should help regularly check children's hair when there is a known case of head lice in the center. Because almost all centers will have outbreaks of head lice periodically, and because the "hysteria"

produced by head lice is far greater than their threat to health, this is a prime area for preventive, anticipatory parent information. A well-organized and prompt response to the first few cases can prevent a widespread problem.

6. If a case is identified, the center should follow cleaning procedures outlined above.

Figure 57
Sample Letter on Head Lice

Dear Parent or Guardian:

______A child in our center has head lice.

______Your child has head lice.

PLEASE TAKE THE FOLLOWING PRECAUTIONS

1. Check your child's hair for eggs (nits).
2. If you suspect your child has head lice, see your health care provider for diagnosis and treatment.
3. Tell us if your child is diagnosed as having head lice.
4. If head lice are diagnosed, do not send your child to the center until s/he has been treated.

What are head lice and how do you know if your child has them?

Head lice are very small, light-brown insects (less than one-eighth inch long) which live only in people's hair, especially the back of the scalp, above the neck, and behind the ears. They do not jump or fly; they do not live on animals. They live by biting the scalp or skin and drinking blood. The bites cause intense itching. Lice are not dangerous, but they make a person *very* uncomfortable.

Lice live for 20 to 30 days and lay about six eggs a day. These eggs, called nits, are very small, about the size of a fleck of dandruff but shaped like teardrops or pears, are pearl gray in color, and are glued onto single strands of hair. Sometimes they can best be seen by looking at a few strands of hair at a time held in natural daylight. The nits are very hard to pull off the hair (not like dandruff which can be brushed out easily).

Usually, you will not see the lice, only the eggs. You will need to look carefully. Spend about ten minutes and start with the hair on the back of the head. If you are not sure, ask your health care provider to check your child's head.

How does a person get head lice? Head lice are very easy to catch, both for children and adults. Having lice is *not* a sign of not being clean or having a dirty house. The lice can crawl from head to head, or from a personal item like a hat or pillow to a head. The eggs or nits may be in combs, brushes, hats, scarves, etc., and they may be passed on and then hatched on the next person. Head lice spread only from person to person; you cannot catch them from grass, trees, or animals.

If your child does have head lice, your health care provider may want to treat everyone in your family. Regardless, you should check everyone's hair carefully. Anyone else with nits should definitely be treated.

How do you get rid of head lice?

1. There are several medicines, used as shampoos, available to treat head lice. Kwell Shampoo* and Prioderm Lotion* are available by prescription only. Other products such as RID*, REC Shampoo*, XXX*, and A-200 Pyrinate* are available over-the-counter. Your doctor will tell you which is best.

   All of these products must be used carefully, and all safety guidelines must be observed. It is especially important to consult a physician before treating (1) infants, (2) pregnant or nursing women, or (3) anyone with extensive cuts or scratches on the head or neck.

   Although all these products will kill lice, none will kill 100 percent of the nits. Nit removal may be time-consuming and difficult due to their firm cementing onto the hair. A solution of vinegar and water may help to dissolve the "cement" and make removal easier. There are special, fine-tooth combs to aid in nit removal; a regular comb will not remove them. A daily nit check for the next ten days is advisable; if you see new nits (less than one-fourth inch from the scalp) or newly hatched lice, it may be necessary to repeat the treatment. *Too many treatments can be dangerous; follow your health care provider's instructions.*

2. Clean all personal items, giving special attention to the following:

   - *Clothes* -- especially coats, sweaters, hats, scarves, pajamas, robes, nightgowns.
   - *Bedding* -- sheets, pillowcases, blankets, pillows.
   - *Toiletries and Towels* -- combs, brushes, curlers, barrettes, etc.
   - *Furry or cloth toys* -- especially those that have been near the child's head or in the child's bed.

---

*Brand names are mentioned for identification purposes only and are not an endorsement. Other similar products may also be used.

WAYS TO CLEAN PERSONAL ITEMS

Choose one of the following methods for each item to be cleaned:

a. Wash in *hot* water in washing machine; dry as usual.

b. Put in *hot* dryer for 20 minutes.

c. Dry clean.

d. Store in sealed plastic bags for 30 days (any eggs present will hatch, but will die for lack of food, i.e., blood. Any lice will also die). This method is especially good for blankets, pillows, toys, and clothing that are hard to wash.

e. Boil combs, brushes, curlers, etc., for 10 minutes.

f. Soak in 2 percent Lysol and water or a bleach solution (1/4 cup bleach to one gallon water) for one hour.

3. Careful vacuuming of carpets, floors, and furniture is all that is necessary for the rest of the house. *Insecticide sprays are not recommended;* they can be harmful to people and animals.

When can my child go back to the center?

Your child may go back as soon as the shampoo has been given, you have removed as many nits as possible from your child's hair, and you have cleaned or stored personal items. [Insert your center's policy on return if different from this statement.] Keep checking your child's hair for new nits for at least two weeks.

Generalized Infections/Total Body Infections

GENERAL PRINCIPLES

■ WHAT ARE THEY?

These generalized infections caused by direct contact can be more serious than the skin infections previously described. They can cause no illness, mild illness like skin sores (cold sores), or a total body illness. Some are treatable (syphilis), others are not (cytomegalovirus). What they have in common is the way they spread from person to person.

■ WHO GETS THEM?

Anyone can get them. With many of these germs, once they get into the body, they may stay in body secretions for months or years, even if a person appears totally healthy. Such people can spread the germ around, even though they are not sick; they are called *carriers* of the germ. They may or may not know they are carriers.

■ HOW DO YOU GET THESE DISEASES?

The germs that cause these illnesses spread when the secretions they are in (such as saliva) are able to penetrate the skin or mucous membrane of another person. This allows the germ to enter the body and multiply. It can occur if the germs get on skin which is broken, cut, or scraped. It can also occur when the secretions have contact with mucosal surfaces such as the inside lining of the mouth, eyes, nose, rectum, or sex organs. These infections may also be transmitted from an infected mother to her newborn infant.

STOP SPREAD

Since it is not always possible to know when these germs are in body secretions, *every bodily secretion should be treated as possibly contagious.* This means:

1. Handwashing is extremely important. Staff and children should wash their hands well after *any* contact with blood, saliva, urine, stool, skin sores, or genital secretions.

2. Disposable items (such as diapers, tissues, bandages, paper towels) that are stained with body secretions should be placed in a lined, covered container, which is kept away from food and child care materials.

3. Washable items (clothes, towels, sheets) that become stained with body secretions should be stored separately in plastic bags and sent home for separate laundering and bleaching.

4. Surface areas (tables, floors, chairs, etc.) and toys that become stained with body secretions or blood should be washed and disinfected with bleach solution. [*Disinfecting surfaces contaminated with blood requires using the strong bleach solution of one part bleach to ten parts water.*] Remember to clean or dispose of cleaning items (mops, rags, towels, etc.) properly.

5. Do not permit aggressive behavior (biting, scratching).

6. Do not allow sharing of personal items that may have been contaminated with blood or other body fluids (toothbrushes, washcloths, teething rings).

CYTOMEGALOVIRUS (CMV) INFECTION

■ WHAT IS IT?

Cytomegalovirus is a very common virus, found especially in small children. In the vast majority of cases, an infection causes no symptoms at all. Sometimes it causes a "mononucleosis"-like illness (fever, tiredness, swollen glands) in children or adults.

Once a person is infected with CMV, the virus can remain in the body for long periods of time. An infected person can "shed" the virus into body secretions (such as saliva and urine) for as long as several years, usually without ever having any symptoms of illness.

Once a person has been infected, the body develops substances called *antibodies*. The presence of antibodies means that the person cannot get another new infection from CMV, but the antibodies do NOT eliminate the existing virus from the body. Again, the virus usually doesn't cause any problems or symptoms of illness.

CMV is of concern in day care only because of the problems it may present for pregnant women. If a pregnant woman *who has never had CMV* becomes infected, particularly in the first three months of pregnancy, the fetus may also become infected. Rarely, this infection in the fetus can cause mental retardation, hearing loss, or other serious problems. The mother usually does not know she is sick or has only a mild flu-like illness.

■ WHO GETS IT?

CMV is a very common infection. In the United States, at least 40 percent of 35-year-old adults have antibody to CMV (that is, have been infected with CMV at some time in the past). Most often, CMV is caught in early childhood, especially between the ages of one and two when children cannot control their secretions. The virus can spread to people with regular, close physical contact with the child's secretions (for example, family members and caregivers). At any one time, a day care center is very likely to have a number of children (as many as one in five) who have CMV in their urine and saliva, but who show no signs of illness. Infection in a healthy child is not serious and probably protects the child from repeat infections.

HOW DO THEY GET IT?

CMV is passed out of ("shed" from) the body in urine, saliva, genital tract secretions; rarely, it may be found in the blood. Shedding of the virus can occur off and on for several years. Spread of the virus requires direct contact with infected secretions, which are then transferred to a mucosal surface (inside the mouth, genital tract, or lining of the eye) or into a person's bloodstream (through a break in the skin, needlestick, or blood transfusion). Spread between children can possibly occur by sharing mouthed objects or toys that have infected saliva on them. The virus can survive several hours on surfaces outside the body.

HOW IS IT DIAGNOSED?

Most persons with CMV are not diagnosed because they show no symptoms. The CMV virus can be cultured from infected fluids; this can take up to four weeks. In special circumstances, a person can have a blood test for the antibody to CMV.

SHOULD THEY BE EXCLUDED OR SENT HOME?

Children who are known to have CMV *do not need to be excluded from day care.* The center most probably has other children who have CMV. Special attention to handwashing after contact with bodily secretions such as urine, saliva, and blood, particularly by women of childbearing age, is always advised.

WHERE TO REPORT IT?

There is no need to report CMV infection, as it is common and frequently occurs unrecognized undiagnosed in the community.

STOP SPREAD

1. Practice the handwashing and cleanliness procedures outlined under "General Principles."
2. Be careful in handling and disposing of diapers or urine-stained clothing, and wash hands after diaper changes/toileting.
3. Adults, but especially pregnant women or women trying to become pregnant, should *always* wash their hands after contact with excretions and secretions of children.
4. *Do not allow sharing* of mouthed objects or food. Wash and disinfect mouthed toys daily.
5. A child's urine- or saliva-contaminated clothing should be stored separately in a plastic bag, and sent home for laundering.

HERPES SIMPLEX INFECTIONS

WHAT ARE THEY?

Herpes simplex viral (HSV) infections are characterized by skin blisters or sores which can be very painful. The virus remains in nerve cells once a person is infected, and HSV tends to recur in the same place again and again. There are two types of herpes virus - HSV type 1 (usually found in the mouth) and HSV type 2 (usually found on the genitals).

HSV type 1 is extremely common, and 70 to 90 percent of adults have had infection. Usually the first infection occurs in childhood, is mild, and often unnoticed. It may come in the form of *"gingivostomatitis"* -- fever accompanied by widespread painful ulcerations (sores) in the mouth. HSV usually recurs (the virus "reactivates" from its home in nerve cells) as *"cold sores"* -- single or multiple blisters around the lip. Rarely, HSV can be spread by direct touching to cause infection on a finger (*"herpetic whitlow"* -- painful recurrent blisters of a finger) or eye (*"herpetic keratitis"* -- recurrent ulcerations of the cornea).

HSV type 2 is the cause of the most cases of genital herpes. It occurs primarily in adults, and is sexually transmitted. (Note: occasionally HSV type 1 may be found in the genital tract and HSV type 2 may be found in the mouth.) The first infection is frequently unnoticed and without symptoms. However, it can also cause painful genital blisters and ulcers accompanied by fever and can last two weeks. Recurrence is common and usually comes in the form of localized, less painful ulcers which go away in days and are not accompanied by fever. Recurrence may also be asymptomatic.

Herpes of the newborn is most often caused by HSV type 2, and occurs when a newborn infant passes through an infected birth canal (that is to say, when an infant is delivered vaginally when the mother has the herpes virus present in the cervix). The resulting illnesses range in severity from skin blisters to total body disease with death or severe brain damage. An infant who survives may have recurrent skin blisters due to HSV.

Except in a newborn infant of less than one month, herpes infection in children is generally caused by HSV type 1 and, while uncomfortable, is rarely serious. Persons who have severe eczema or immune system problems may have more severe infections with herpes.

WHO GETS THEM?

HSV type 1 is most common in preschool children, while HSV type 2, due to its sexual transmission, is more common in adults. However, HSV type 2 may be seen in children in unusual circumstances or as a result of sexual abuse.

HOW DO THEY GET THEM?

HSV is shed into the secretions of the blisters and ulcers. Spread of both HSV 1 and 2 requires direct contact of virus-containing secretions with a *mucous membrane* (inside the mouth, lining of the eyes, rectum or genitals) or with broken skin (such as a cut).

The virus can survive up to four hours on surfaces, and thus shared mouthed objects contaminated by virus-containing saliva could transmit infection of the mouth. It would be extremely unlikely, however, for an object such as a toilet seat to transmit the virus, since transmission requires contact with internal rectal or genital mucosa. Because young children have less control over body secretions, spread is much more likely to happen in day care centers than in schools or the workplace.

It would also be unlikely for HSV from a *child's* mouth, skin or genital lesion to cause *genital* herpes in another person, as transmission would require direct contact with the other person's genital area. In normal child care situations, this would not occur.

HOW ARE THEY DIAGNOSED?

Most of the time, the appearance of the blisters or sores is very distinctive, and this is how they are diagnosed. Occasionally a doctor may examine material under the microscope or do a special viral culture.

HOW ARE THEY TREATED?

Antiviral therapy for HSV infections has recently become available. Generally speaking, this therapy is useful only for serious HSV infections, such as in the newborn, infection of the brain or eye, or for certain cases of genital herpes. There is no evidence that these medicines are of any benefit to the common HSV infections in the mouth.

WHEN SHOULD PEOPLE BE EXCLUDED?

Children or staff with open, oozing sores that cannot be covered should not attend or work. This includes all cases of *herpetic whitlow* if the sores are not crusted.

Children or staff with skin blisters in locations other than the mouth or finger which can be covered or with genital herpes *should not be excluded.* Careful handwashing and general hygiene should be observed and staff should wear gloves when there is a chance of touching blisters on children (for example, changing a dressing or diapers).

Staff with *oral* (mouth) blisters should NOT care for children because of the potential risk of spread to children through diapering or other child care activities that involve close physical contact. Staff can continue to work in other administrative capacities.

WHEN CAN THEY COME BACK?

- Children in preschool day care with oozing HSV sores of the *mouth* should stay home until the blisters are crusted over (usually within four to five days).
- Children or staff with *skin* blisters which cannot be covered should stay home until the blisters are crusted over.
- Children or staff with *herpetic whitlow* (herpes blisters on the finger) should stay home until the blisters are completely crusted over.

WHERE TO REPORT IT?

There is no need to report HSV infections, either type 1 or type 2, other than in the newborn period.

STOP SPREAD

1. Always wash hands after contact with secretions of the mouth, skin or genitals.
2. Toys or surfaces that are mouthed by children should be washed and disinfected at least once daily.
3. Do not allow sharing of mouthed objects or food.
4. Children's soiled clothing should be separately stored in a sealed plastic bag and sent home for laundering.

SEXUALLY TRANSMITTED DISEASES

WHAT ARE THEY?

Sexually transmitted diseases are infections caused by a variety of germs (bacteria, viruses, and parasites) that are transmitted primarily by intimate sexual contact with infected secretions. These infections include gonorrhea, syphilis, chlamydia, and genital herpes simplex. Two viral infections discussed elsewhere in this chapter, CMV and Hepatitis B, can also be transmitted sexually because the viruses are present in genital secretions.

WHO GETS THEM?

These diseases are primarily seen in sexually active adolescents and adults. Some infections can be passed from mother to newborn during pregnancy or as the infant passes through an infected birth canal. Examples of this include gonococcal or chlamydial eye infections (opthalmia neonatorum), herpes simplex of the newborn, or congenital syphilis. CMV and Hepatitis B can also be transmitted in this manner.

With the exception of newborn infants who become infected during pregnancy or the birth process, the presence of one of these infections in a child should raise the possibility of sexual abuse. In children, CMV and Hepatitis B are almost always transmitted by other mechanisms and should NOT be considered possible indicators of sexual abuse.

HOW DO THEY GET THEM ?

These diseases are, in general, transmitted through intimate, sexual contact. They are NOT spread through the air, by contact with objects like toilet seats, or by casual contact. They are spread when infectious secretions come in *direct* contact with a mucosal surface (such as genitals, inside the mouth, or the lining of the eye).

HOW ARE THEY DIAGNOSED?

These diseases can be diagnosed by a variety of tests. The following table reviews the symptoms, diagnosis, and treatment of the major sexually transmitted diseases (Figure 58).

NOTE: The diagnosis of one of these sexually transmitted diseases in a young child (excluding those infections passed from mother to newborn) is reason to begin an appropriate investigation for sexual abuse. See Chapter 14 on Child Abuse and Neglect; in particular, see Figure 33, Indicators of Sexual Abuse.

Figure 58

Symptoms/Diagnosis/Treatment of Major Sexually Transmitted Diseases

GONORRHEA

Cause: Bacteria (Neisseria gonorrhoeae)
Symptoms: Vaginal/rectal pus discharge or redness
Pain or pus during urination
Sore throat
Pus and eye discharge in newborn less than one week old*
Diagnosis: Culture of appropriate area
Treatment: Antibiotics

CHLAMYDIA

Cause: Bacteria-like germ (Chlamydia trachomatis)
Symptoms: Vaginal/rectal pus discharge or redness
Pain or pus during urination
Pus and eye discharge in newborn less than one month*
Certain pneumonia syndromes in infants less than three months*
Diagnosis: Culture or rapid test of scraping of infected area
Treatment: Antibiotics

SYPHILIS

Cause: Spirochete bacteria (Treponema pallidum)
Symptoms: Painless, hard ulcer usually on genitals, with swollen groin glands
Body rash (symmetrical, brownish) with flu symptoms
Shallow ulcerations on mucosal surfaces (mouth)
Moist, gray genital "warts"
Syndrome of congenital syphilis*
Diagnosis: Blood test
Treatment: Antibiotics

HERPES SIMPLEX

Cause: Virus (Herpes simplex type 2)
Symptoms: Recurrent, painful, tiny blisters or ulcers, usually on the genitals
Swollen groin lymph nodes
Severe generalized disease of skin, brain, liver*
Diagnosis: Viral culture or scraping of infected area viewed under the microscope
Treatment: First (primary) infection: an antiviral ointment or oral medicine may be given
Recurrent infection: usually no treatment, occasionally oral antiviral medicine

NONSPECIFIC VAGINITIS

Cause: Bacteria (Gardnerella vaginalis)
Parasite (Trichomonas vaginalis)
Symptoms: Vaginal discharge and irritation
Diagnosis: Exam of vaginal fluid under the microscope
Treatment: Antibiotics

---

*Mother to newborn transmission

SHOULD PEOPLE BE EXCLUDED?

A child who has a sexually transmitted disease is not contagious to others unless *direct* mucous membrane contact with the infected area occurs, and should not be excluded from day care. The child should receive appropriate treatment for the infection, and an investigation for possible sexual abuse should be started.

A staff member with a sexually transmitted disease is also not a risk to others in the center, and should be allowed to work. The adult should receive appropriate treatment and counseling regarding these infections.

WHERE TO REPORT THEM?

The following sexually transmitted diseases must be reported directly to the State Department of Public Health by the diagnosing health care provider. If you have a suspicion that the disease occurred because of sexual abuse, you must report the case to the Department of Social Services.

Gonorrhea
Syphilis
Chlamydial genital infection
Pelvic Inflammatory Disease
Granuloma inguinale
Lymphogranuloma venereum
Chancroid
Ophthalmia neonatorum
Neonatal herpes

Free diagnosis and treatment are also available at Venereal Disease Clinics sponsored by the state Department of Public Health.

STOP SPREAD

1. Routine handwashing procedures after every contact with a genital area (i.e., toileting) should be followed.
2. Watch for physical signs of abuse when changing and toileting a child. Be alert to other signs of possible sexual abuse.
3. Make a referral to a health care provider if such signs are found.
4. If disease is diagnosed and sexual abuse is suspected, the center, along with the health care provider, should file a 51-A report with the Department of Social Services.

Diseases Spread Through Blood Contact

GENERAL PRINCIPLES

In this section, two serious viral infections that are spread by contact with infected blood will be discussed. They are Hepatitis B and AIDS (Acquired Immune Deficiency Syndrome)/HIV Infections.

The viruses that cause these illnesses can spread when blood that contains the virus enters the blood stream of another person. This can happen through the accidental or intentional puncture of the skin by a contaminated needle. Spread can also occur if infected blood comes in contact with a broken surface of the mucosa (such as the inside lining of the mouth, eyes, nose, rectum, or sex organs). These infections can also be transmitted by an infected mother to her newborn infant.

Once these viruses enter the body, they may stay for months or years, even if the person appears healthy. They can be spread by such a person, called a "carrier" of the germ, even if the person is not sick.

These infections are much more difficult to "catch" or to transmit from one person to another than any of the other diseases discussed in this chapter.

General measures for the prevention of these diseases are the same as those for other diseases caused by direct contact. Because it is not always possible to know when someone is infected with germs spread by blood contact, *all blood and mucosal secretions should be treated as possibly contagious.*

Because *blood* can potentially contain these two viruses, *all blood spills and blood-contaminated surfaces should be disinfected (after cleaning) with a STRONG BLEACH solution of one part bleach in ten parts water.*

Disposable latex gloves should be considered when contact with blood or blood-containing body fluids is likely. This includes the following situations:

- *when contact with blood or blood-containing body fluids from a child is anticipated, particularly if the caregiver's hands has open cuts or abrasions.*
- *when cleaning surfaces that have been contaminated with blood or other body fluids.*

HEPATITIS B

WHAT IS IT?

Hepatitis B is a viral infection of the liver. Symptoms of infection include fever, loss of appetite, nausea, jaundice (yellowing of the skin and whites of the eyes), and occasionally pain of the joints and a hivelike skin rash. Illness can range from infection without symptoms, to mild symptoms without jaundice, to severe illness with jaundice, to the very rare event of rapid liver failure and death. As with Hepatitis A infection, young children are less likely to be jaundiced or show symptoms of illness. Unlike Hepatitis A infection, Hepatitis B can cause chronic infection with persistent "shedding" of the virus into body secretions and blood in up to 10 percent of those infected. Persons with such chronic infections are called virus *carriers*. These persons can develop chronic liver disease, cirrhosis with liver failure, and liver cancer years after infection. An infected mother can transmit the infection to her newborn infant. Although these infants often show no obvious symptoms of Hepatitis B, they have a high likelihood of becoming carriers.

WHO GETS IT?

Unlike Hepatitis A, which is spread through infected stool, Hepatitis B is transmitted when blood or body fluid containing the virus gets onto broken skin or a mucosal surface (inside the mouth, eyes, rectum or genital tract). Hepatitis B infection, therefore, is much more difficult to pass from one person to another. Infection with Hepatitis B is most common in persons who have contact with other people's blood in a manner that could allow blood-to-blood contact, such as health care providers or laboratory technicians in whom an accidental skin puncture with a blood-contaminated needle could occur, or intravenous drug abusers who share needles. People who are sexual contacts to a person with Hepatitis B are also at high risk of contracting the infection, because Hepatitis B can be sexually transmitted through genital mucous membrane contact with infected genital tract secretions. Infants born to mothers with Hepatitis B infection are at high risk of becoming infected. Transmission of infection in a household setting is less likely, although transmission has been known to occur rarely in situations where continuous sharing of personal items that may be contaminated with infected blood (such as toothbrushes, razors, etc.) occurs.

HOW DO THEY GET IT?

The virus has been found in almost all body fluids; however, only blood, genital fluids and, to a lesser extent, saliva, have been found to be infectious, that is, able to spread the disease.

Spread requires contact with the infected fluid through the skin (needlestick, contamination of a cut, blood transfusion) or through a broken mucosal surface (as might occur during sexual contact or intense shared salivary contact); an unborn child can get it from its mother. The virus is *not* transmitted by casual social contact such as hugging or hand shaking or via food or water.

Transmission in a day care setting has not been reported. The risk of spread is higher from an infected person with behavioral and/or medical problems that may increase the possibility of transfer of infected fluid. Examples of such problems are biting behavior (that draws blood) and oozing skin sores. Because a person who is a carrier may have no signs of illness, *HANDWASHING AFTER CONTACT WITH ANYONE'S BLOOD OR SECRETIONS IS THE BEST PREVENTIVE MEASURE.*

■ HOW IS IT DIAGNOSED?

Hepatitis B infection is diagnosed by a blood test.

■ HOW IS IT TREATED?

There is no specific treatment for Hepatitis B infection. Most often, the body's defense system successfully fights off the infection, and the person becomes immune. However, medical follow-up is important to ensure that severe complications do not occur during the acute infection, and to watch for the less likely occurrance of chronic infection.

Recently a new vaccine has been licensed for the prevention of Hepatitis B. This vaccine is highly effective and considered very safe, but is relatively expensive and must be given in three doses over six months. It is recommended for persons who have never had Hepatitis B (screening for prior infection by blood test is often recommended) and who have a high risk of exposure, such as health care workers, laboratory technicians, sexual contacts to persons with acute Hepatitis B, and infants born to infected mothers. A day care center would not ordinarily be viewed as a high-risk setting.

If a person is known to have been exposed to Hepatitis B, (such as by a needlestick, sexual contact with an acutely infected person, or a deep bite that has drawn blood), a special immune globulin, given by injection as soon as possible following exposure, can be given to prevent infection. It is recommended that the vaccine series also be given following the immune globulin injection.

SHOULD PEOPLE BE EXCLUDED?

Staff persons ill with Hepatitis B should stay home until they feel well and fever and jaundice are gone. Transmission of Hepatitis B requires contact of infected fluid (primarily blood and genital secretions) with the bloodstream or broken mucous membrane of another person. In a day care setting, where needlestick, sexual exposure, and the sharing of potentially contaminated personal items as toothbrushes or razors would not occur, transmission of the virus from an employee to other employees or children at the center would be unlikely. A staff person with chronic Hepatitis B infection who has open, oozing sores that cannot be covered should not attend the center until the skin sores are healed. Therefore, unless a staff member had open, oozing sores, there would be no reason to exclude such a person from employment once recovered from acute infection.

A child who is a carrier of the virus does not have to be excluded from day care. However, because young children (particularly under three years old) lack control of their body secretions, often share items which may be contaminated with such secretions, and may display behavior such as biting that raise the risk of possible virus transmission, a more restrictive environment may be desired for these children. In addition, careful blood precautions as outlined below should be followed.

The decision to allow a child with acute Hepatitis B or a child who is a carrier of the virus to attend a center would depend on several factors, including:

- the age of the child (children under three years are more likely to engage in behaviors, such as biting and chewing on objects, that would present some risk to others; children between four and five years are less likely to do so; school-aged children would be viewed as similar to an adult unless high-risk behaviors were noted.)
- the developmental level of the child
- the behavioral patterns of the child
- the ability of the center to closely supervise the child to avoid sharing of chewed objects with others

Your health consultant, the local Board of Health, and the state Department of Public Health will help you make such decisions.

WHERE TO REPORT IT?

Parents and staff must be notified of acute Hepatitis B infection, which also should be reported to your health consultant and your local Board of Health. Hepatitis B carriers are not required to be reported.

If someone is known to be a carrier, you will want to talk with your health consultant. If your center has one or more known carriers of Hepatitis B, all staff should be informed of this fact and should be carefully trained in measures to prevent spread (such as the blood precautions discussed under "General Prinicples" above and under "Stop Spread" below.) They should be informed of the availability of the vaccine and of its effectiveness and safety. You should strongly consider telling parents of other children in the same class in the center and offering information about Hepatitis B, prevention, and the availability of vaccine. Your health consultant, your local Board of Health, and the state Department of Public Health can be helpful in this process.

In the process of adequately protecting staff and other children, it is vital that the confidentiality of the medical records of the Hepatitis B carrier(s) be respected and that the individual carrier(s) not be stigmatized. This means that the names of specific children are not released to other parents and that any precautions or procedures set in place be used for *all* children and staff, at least in the affected classroom(s).

STOP
SPREAD

1. All general procedures for handwashing and cleanliness at the center should be very carefully observed.

2. Carefully observe all the instructions for dealing with blood, outlined under "General Principles." Since often you do not know who carriers are, it is wisest to *always treat blood as a potentially dangerous fluid.* With a known carrier of Hepatitis B, careful blood precautions must always be taken.

3. Do *not* allow sharing of personal items that may become contaminated with infectious blood or body fluids, such as toothbrushes, food, or any object that may be mouthed.

4. Disposable items contaminated with blood or body fluid should be placed in plastic bags in covered containers.

5. Clothing or other washable items stained with blood and/or secretions should be stored separately at the center in a plastic bag to be sent home with the child for appropriate cleaning. Bleach as well as routine washing is recommended for clothing with blood or secretion staining.

6. Surfaces or toys contaminated with blood or body fluids should be cleaned with a *strong* bleach solution (1 part bleach to 10 parts water) as soon as possible. Objects may also be disinfected by boiling for ten minutes.

7. In general, discourage aggressive behavior (biting, scratching) at the center.

8. Gloves are preferred when cleaning blood spills, especially of a known Hepatitis B carrier. Wash hands well afterwards.

9. In the event of a specific infectious exposure to a person with Hepatitis B (such as a bite that causes bleeding), contact your local Board of Health and the exposed person's health care provider for advice whether the exposed person should receive a preventive immune globulin injection and the vaccine series.

10. If the center cares for multiple children with Hepatitis B, a vaccination program for non-immune employees and children should be strongly considered. Discuss this with your health consultant.

AIDS/HIV INFECTIONS

WHAT ARE THEY AND WHAT IS YOUR ROLE?

HIV (Human Immunodeficiency Virus) infections, which include AIDS and ARC (AIDS-related complex), are very serious viral infections. Since there is new information coming out about AIDS and HIV all the time, it will be important for you not only to read what is in this manual but also to keep up with new developments. The state Department of Public Health is an excellent source of information and you can always call with questions. (Staff persons from the AIDS Program can be reached at 617-522-3700.) If a child with known HIV infection or AIDS applies to your center, the Department of Public Health, in conjunction with the child's physician, will help you decide whether or not the child should attend the center, and if so, what procedures should be followed.

The information in this section is taken from current materials from the Massachusetts Department of Public Health including an AIDS Public Health Fact Sheet and "Recommendations for Caretakers of Children with Clinical AIDS or Evidence of Infection with HIV," issued by the Governor's Task Force on AIDS.

These guidelines recommend against the placement of children age three and under in group settings and set certain conditions for group participation for four and five year olds and the developmentally disabled. There is no need for individual centers to adopt specific policies or exclusion rules, outside of those outlined here, as the odds of having a child with AIDS are *very* remote. Each case should be handled in cooperation with the state health department.

If your center or program also includes children of school age (e.g., kindergarten class or after-school programs), you should also obtain a copy of the current state "AIDS School Attendance Policy" from your local school system or the Department of Public Health.

RECOMMENDATIONS FOR CARETAKERS OF CHILDREN WITH CLINICAL AIDS OR EVIDENCE OF INFECTION WITH THE HIV VIRUS INFECTION

Purpose

The intention of the Governor's Task Force on AIDS concerning the preschool child and the developmentally disabled with clinical AIDS or evidence of infection with the AIDS-associated virus HIV is to establish standards:

1. To protect against risk of transmission of the AIDS associated virus among preschool aged children and individuals with developmental disabilities in group settings.
2. To protect the susceptible AIDS patient from infections.
3. To inform the caregiver and other family members about the management of the child with AIDS.
4. To help the child with clinical AIDS or evidence of infection with the AIDS associated virus, HIV, to lead as normal a life as possible.

Background

AIDS (Acquired Immune Deficiency Syndrome) is a disease that leaves an individual vulnerable to illnesses that a healthy immune system might otherwise overcome. It is caused by a virus, Human Immunodeficiency Virus (HIV), also known as Human T-cell lymphotropic virus type III (HTLV-III). Epidemiologic studies show that AIDS is transmitted by intimate sexual contact or blood to blood contact, or from an infected pregnant mother to the fetus. There is no evidence of casual transmission by sitting near, living in the same household, or playing with an individual with clinical AIDS or evidence of infection with the AIDS associated virus, HIV.

The Centers for Disease Control noted in the August 30th, 1985 "Morbidity and Mortality Weekly Report" (MMWR) that none of the identified cases of HIV infection in the United States are known to have been transmitted in school, day care, or foster care settings or through casual person-to-person contact. Further studies of family members of patients infected with HIV have failed to demonstrate tranmission outside of sexual contact or *in utero* exposure.

However, care of HIV-infected preschool-aged children or developmentally disabled HIV-infected persons in a group setting raises special *theoretical* considerations that are not relevant in older children or with adults.

Because children at this age, particularly children in the 0-3 age group and the developmentally disabled, may lack control of their bodily secretions or may display behavior such as biting, there may be theoretical reasons to require a more restrictive environment for these children until more is known about transmission in these group settings.

■ RECOMMENDATIONS ON THE ATTENDANCE OF PRESCHOOL CHILDREN AND THE DEVELOPMENTALLY DISABLED WITH CLINICAL AIDS OR EVIDENCE OF HIV INFECTION IN GROUP SETTINGS

1. Preschool children with clinical AIDS or evidence of infection with HIV from birth to age four (48 months) should not attend a group setting in which there are other children in this age group.

2. Preschool children four and five years old, if not already in kindergarten, and the developmentally disabled, may attend a group setting unless:

    - The child has cutaneous (skin) eruptions or weeping lesions that cannot be covered.

    - The child exhibits biting behavior or has frequent incontinence or drooling. However, if it can be determined that supervision of the child is adequate to ensure that the Standards referred to below can be maintained, attendance may be permitted. The child's preschool caregiver should collaborate with the personal physician on the appropriateness of the child's attendance at the preschool in the above circumstances.

3. Siblings of children with clinical AIDS or evidence of infection with HIV should be able to attend school without any restrictions.

4. The child's personal physician is the primary manager of the child with clinical AIDS or evidence of infection with HIV. Management includes consultation with the preschool caregiver as to the appropriateness of the child's attendance at pre-school in accordance with the policy outlined above.

    - The child's personal physician is responsible for reporting cases of AIDS directly to the Massachusetts Department of Public Health. The preschool caregiver will be notified and will provide assistance in identifying those educational or health care agents with an absolute need to know.

    - Only persons with an absolute need to know should have medical knowledge of a particular child.

    - Notification should be by a process that would maximize patient confidentiality. Ideally, this process should be direct person-to-person contact.

    - If preschool authorities believe that a child with clinical AIDS or evidence of infection with HIV virus has evidence of the conditions described in #2 above, then the preschool caregiver, after consultation with the child's physician and the state epidemiologist at the Department of Public Health (in unusual circumstances), may dismiss the child from the class.

5. Since the child with clinical AIDS or evidence of HIV virus infection has a somewhat greater risk of encountering infections in the school setting, the child should be excluded from school if there is an outbreak of a threatening communicable disease, such as chickenpox or measles, until he/she is properly treated (possibly with hyper-immune gamma globulin) and/or the outbreak no longer presents a threat to the child.

6. There is a blood test for detecting the presence of antibody to HIV. Antibodies are substances produced by white blood cells that help fight infection caused by viruses or bacteria. The presence of antibodies indicates that a person has, at some unknown time, been exposed to the HIV virus in a manner sufficient for the body to respond by producing antibodies. Some antibody positive individuals will remain carriers of the virus. Additional tests to determine the carrier status in individuals are not always reliable or available outside of research settings.

   Routine screening for HIV antibody is not recommended. The primary physician may recognize individual situations where antibody testing would be useful in medical management. If a child has an HIV antibody test and it is positive, the pre-school caregiver will be notified by the primary physician (who will have explained the issues to the child's parent or guardian and *obtained consent* for the necessary communication). The precautions outlined in this policy will be observed for that child.

7. In-service education of appropriate school personnel should ensure that accurate information about AIDS is available.

■ STANDARDS FOR CARE

Standards for Care of Children with Clinical AIDS or Evidence of Infection with HIV (Attachment A to the Governor's Task Force report) should be observed by caregivers of the preschool child or developmentally disabled individual with clinical AIDS or evidence of infection with HIV. (The Standards are available from the Department of Public Health if the need arises.) These standards were developed in order to both maximize appropriate socialization experiences for these children and to standardize the management of their care.

Vaccine-Preventable Diseases

GENERAL PRINCIPLES

WHAT ARE THEY?

This is a group of diseases includes measles, mumps,rubella, polio, pertussis, diphtheria and tetanus. Prior to the implementation of immunization programs, these diseases were a major cause of widespread illness, often with permanent medical complications and even death. These diseases were a problem especially in children, although adults were also affected.

Recently, new vaccines has been licensed to prevent Haemophilus influenzae type B infections and Hepatitis B. These diseases and the vaccines are discussed in previous sections in detail.

WHO GETS THEM?

Some people believe that these diseases are no longer a problem in the United States or that children can't get them anymore. This is not true, and cases of these diseases still occur, particularly in unimmunized or inadequately immunized children and adults. In recent years, about 100 cases a year of these diseases are reported in Massachusetts.

Children in day care and their adult caretakers are especially at risk. This is because the children may be too young to be fully immunized and because the close contact that occurs in the child care setting allows easy spread of any disease that is brought in. In addition, programs that have a relatively young staff (born after the late 50's and early 60's) are at particular risk because this age group is too young to have gotten natural immunity from exposure during the days before widespread vaccination, but graduated from high school before vaccination for all these diseases was required.

In the following sections, each disease will be presented briefly, in our standard format. Although it is highly unlikely that you will ever see a case of any of these diseases, it is *very important* that you be aware of them and of your vital role in preventing their spread.

STOP SPREAD

1. All children in day care must be immunized as completely as possible for their age, in accordance with Department of Public Health regulations. (See earlier section of this chapter.)
2. All adults working in a day care setting (including volunteers) should have immunity to the following vaccine-preventable diseases:

diphtheria, tetanus, measles, mumps, rubella, and polio. (Adult vaccination against pertussis is not recommended.) Although such immunity is not currently required by either OFC or Public Health regulations, we strongly recommend voluntary enforcement of these standards.

Acceptable evidence of immunity in adults can be provided in several ways, which vary by the age of the adult and the specific disease, as listed below.

- Diphtheria/Tetanus: Documentation of completion of a primary series (three doses) within the past ten years,
  OR
  Documentation of a primary series in childhood and regular boosters every 10 years since.

- Measles/Mumps: Born before 1957
  OR
  Documentation of vaccination with live measles vaccine on or after the first birthday
  OR
  Documentation of physician-diagnosed measles
  OR
  Laboratory evidence of immunity.

  Vaccination for mumps is recommended for males over the age of 20 who are not sure that they are immune.

- Rubella: Documentation of vaccination with rubella vaccine on or after the first birthday
  OR
  Laboratory evidence of immunity.

  A history of rubella, or even a physician diagnosis of rubella, without laboratory confirmation is *not* acceptable. Vaccination during pregnancy is generally not advised. Vaccination should be given after delivery.

- Polio: Born before 1964
  OR
  Documentation of vaccination with a primary series (3 or more doses) of polio vaccine.

3. If a documented case of measles, mumps, rubella, polio, diphtheria, tetanus, or pertussis occurs in your center, you must notify your local Board of Health. They will assist you in starting any necessary identification and vaccination of susceptible children and adults. They will also instruct you on procedures for closely watching for any additional cases and for notifying other parents.

MEASLES

■ WHAT IS IT?

Measles is a very communicable viral illness. It is the most serious of the common childhood diseases. Usually it causes a brownish-red blotchy rash, which begins on the face and spreads down the body over three days, accompanied by high fever, cough, runny nose, and watery eyes. The illness lasts one to two weeks and can be complicated by ear infections, pneumonia, encephalitis (inflammation of the brain), and can cause miscarriages or premature delivery in pregnant women.

■ WHO GETS IT?

Measles cases are generally limited to three groups: 1) children less than 15 months of age (who are too young to have been immunized), 2) those refusing vaccination, and 3) adolescents and young adults who may have received an earlier ineffective measles vaccine prior to 1968, or graduated school prior to the mandatory measles vaccination law. Adults born prior to 1957 are generally considered immune.

■ HOW DO THEY GET IT?

Measles is spread by large infected droplets or direct contact with the nasal or throat secretions of infected persons. It can also be spread by inhaling air which has tiny infectious droplets from sneezes, coughs, etc. It is *one of the most readily* transmissible communicable diseases. The communicable period is greatest PRIOR to and JUST AFTER rash onset.

■ WHEN CAN THEY COME BACK?

A child/staff member with measles should not return until at least four days after the appearance of the rash.

■ WHERE TO REPORT IT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD See "General Principles" section above.

MUMPS

WHAT IS IT?

- Mumps is a viral infection that causes fever, headache, and swelling and tenderness of the salivary glands, particularly the gland at the angle of the jaw. This causes the cheeks to swell. Possible complications include meningitis (inflammation of the coverings of the brain and spinal cord), encephalitis (inflammation of the brain), deafness, and particularly in adolescent or adult males, inflammation of the testicles. The virus may produce a miscarriage if a woman becomes infected during the first trimester of pregnancy.

■ WHO GETS IT?

Most adults over 25 years old have been infected naturally and are probably immune. Mumps may be seen in unimmunized children, or adolescents and young adults who graduated from school prior to laws requiring mumps immunization.

■ HOW DO THEY GET IT?

The mumps virus is found most often in saliva. It is transmitted by direct contact or by droplet spread of the virus in the air through sneezes, coughs, etc. The virus may also be found in urine. Mumps is most infectious 48 hours PRIOR to the onset of symptoms.

■ WHEN CAN THEY COME BACK?

A child/staff member with mumps should not return until nine days after the onset of swelling; or until the swelling has subsided (whichever is sooner).

■ WHERE TO REPORT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD

See "General Principles" section above.

RUBELLA

■ WHAT IS IT?

Rubella is also called German measles. It is a viral illness that is usually very mild and causes a slight fever, a flat, red rash that begins on the face. Over 24 hours, the rash rapidly generalizes to the rest of the body. There is swelling of the glands of the neck, in particular the glands on the back of the neck. The illness lasts about three days. Adult women may have swelling and aching of the joints for a week or so. Rarely, encephalitis (inflammation of the brain) or a temporary bleeding disorder (purpura) can occur, more commonly in adults. As many as half of infections may occur WITHOUT rash.

The most serious problem with rubella is that if a pregnant woman becomes infected, the developing infant can become infected. Stillbirth or miscarriage can occur, or serious birth defects such as heart defects, deafness, blindness, or mental retardation can occur in the infant.

■ WHO GETS IT?

Approximately 15-25 percent of young adults remain susceptible to rubella due to graduation prior to the school rubella vaccination laws. Rubella is most often seen in unimmunized children and in this susceptible adolescent and young adult group.

■ HOW DO THEY GET IT?

The virus is spread by large droplets spread through air (sneeze, cough) or by direct contact with infected nasal or saliva secretions; direct contact with blood, urine, and stool during the infectious period can also spread infection.

■ WHEN CAN THEY COME BACK?

A child/staff member with rubella can return five days after the onset of the rash.

■ WHERE TO REPORT IT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD

See "General Principles" section above.

POLIO

WHAT IS IT?

Polio is caused by a virus and causes an illness that ranges in severity from a mild, unnoticed febrile illness to meningitis (inflammation of the covering of the brain and spinal cord) to paralysis and even death.

WHO GETS IT?

Today, polio cases occur mainly among unimmunized young children or members of groups that refuse immunization.

HOW DO THEY GET IT?

The virus is spread by direct contact with infected stool and throat secretions (phlegm, mucus). Persons are most infectious during the first few days before and after the onset of symptoms.

WHEN CAN THEY COME BACK?

One week from the onset of the disease or after fever is gone, whichever is longer.

WHERE TO REPORT IT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD

See "General Principles" section above.

DIPHTHERIA

WHAT IS IT?

Diphtheria is a very serious bacterial infection of the nose and throat. It causes a sore throat, swollen tonsils with a grayish covering, and swollen neck glands. It can lead to severe throat swelling that can block breathing. The bacteria also produces a toxin (a type of poisonous substance) that can cause severe and permanent damage to the nervous system and heart. Diphtheria is treated primarily with an antitoxin, along with antibiotics. Antibiotics are also given the carriers of the diphtheria bacteria.

WHO GETS IT?

Diphtheria occurs primarily among unimmunized or inadequately immunized people. Booster doses of diphtheria toxoid every ten years after finishing the childhood primary immunization series are needed to maintain protection.

HOW DO THEY GET IT?

The bacteria are spread by direct contact with discharge from the nose, throat, skin, eyes, or other sores of infected persons. Articles or food contaminated with discharge can also spread infection.

WHEN CAN THEY COME BACK?

Patients and carriers of the diphtheria bacteria should receive appropriate treatment, and not return until two cultures from nose, throat, or skin sores are negative for the bacteria; these cultures should be taken at least 24 hours apart after finishing treatment.

WHERE TO REPORT IT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD

See "General Principles" section above.

TETANUS

■ WHAT IS IT?

The tetanus bacteria, which lives in soil, can enter the body through a cut or wound. The bacteria produces a poisonous substance which causes the muscles to go into spasms; paralysis and even death can result. Tetanus used to sometimes be called "lockjaw."

■ WHO GETS IT?

Tetanus occurs almost exclusively in unimmunized or inadequately immunized persons. Booster doses of tetanus toxoid every ten years after finishing the childhood primary immunization series are necessary to maintain protection.

■ HOW DO THEY GET IT?

Unlike the other vaccine-preventable diseases, tetanus is *NOT* spread from person to person. It occurs when the bacteria in soil or dust is introduced into the body through a wound.

■ WHEN CAN THEY COME BACK?

When they are well.

■ WHERE TO REPORT IT?

Your local Board of Health and health consultant should be notified.

STOP

SPREAD

See "General Principles" section above.

Make sure all cuts, scrapes, and puncture wounds are cleaned well with soap and water.

PERTUSSIS (WHOOPING COUGH)

WHAT IS IT?

Pertussis is a very contagious bacterial infection of the respiratory tract. The disease begins with cold symptoms, and over one to two weeks develops into repeated attacks of severe coughing which can last one to two months. The classic "whoop" sound (which gets its name from the sound a child makes when s/he tries to draw a breath after a coughing spell) may not occur, especially in young infants or adults. During the severe coughing stage, seizures or even death can occur, particularly in a young infant, due to a lack of oxygen supply. Antibiotic treatment will reduce the infectiousness of an ill person but may not improve symptoms once a person has developed severe cough.

WHO GETS IT?

Cases are generally seen in unimmunized or inadequately immunized children. Cases can occur in adolescents and adults because immunity decreases with age. These adult cases, who may have very mild symptoms, can spread the infection into a susceptible group of young children. The vaccine against pertussis does not always provide lifetime protection. However, immunization of young children is important because the most serious effects of the disease, including death, are most common among young children.

HOW DO THEY GET IT?

The bacteria is spread by direct contact with discharge from the nose or throat of an infected person, or by breathing in infected droplets in the air where an infected person coughs. The period of greatest risk of spread is the early "cold" stage.

WHEN CAN THEY COME BACK?

A child/staff member should not return to the center until three weeks after the onset of cough, or seven days after the initiation of appropriate antibiotic therapy. Persons with direct contact with a case of pertussis should receive antibiotic treatment to prevent the development or spread of the disease.

WHERE TO REPORT IT?

Parents and staff must be notified. Your local Board of Health and your health consultant should be notified as well.

STOP SPREAD See "General Principles" section above.

Non-Contagious Infectious Diseases

WHAT ARE THEY?

Some diseases are infectious in that they are caused by germs (bacteria, viruses, fungi) or parasites, but are not "catching" or "contagious." That is, they are NOT readily spread from person to person. Two common infections in young children that are not readily spreadable, but can often raise questions about treatment and care, are Otitis Media (infection of the middle ear) and Candida (yeast) infections. A third type of infections, spread from animals to people by ticks, can also present problems. These are discussed in this section.

OTITIS MEDIA (MIDDLE EAR INFECTION)

WHAT IS IT?

Otitis media is an infection of the middle ear: the part of the ear behind the eardrum. There is a small passageway (the Eustachian tube) from inside the throat to the middle ear. It is through this tube that bacteria and/or viruses can travel from the throat area to the middle ear and cause an infection. When infection occurs, pus develops and pushes on the eardrum; this causes pain. Fever is common as well. Sometimes the pressure is so great that the eardrum bursts, and the pus drains out into the ear canal. Although this is frightening for a parent, the child feels better and the drum heals over the hole.

If untreated, the infection could spread to the mastoid bone just behind the middle ear and cause mastoiditis. This used to be a very great problem before antibiotics were available for treatment. Today, the biggest problem from otitis media is the potential for hearing problems. Fluid may remain in the ear for as long as six months after the infection is gone; this is called serous otitis media.

WHO GETS IT?

Anybody can, but middle ear infections are common between the ages of one month and six years, and most common under age three. Some children develop ear infections a few days after a cold starts. Some children have one infection after another; others never have any. The tendency to have infections runs in families.

HOW DO THEY GET IT?

The bacteria and viruses which cause otitis media start out in the throat. About half of the cases of otitis are bacterial and about half viral. It is impossible to tell the germ causing the infection without inserting a sterile needle through the eardrum, pulling out some of the pus or fluid, and culturing it. This is somewhat difficult and done only for special reasons. In general, all middle ear infections are treated with antibiotics as if they were bacterial.

SHOULD THEY BE EXCLUDED OR SENT HOME?

Ear infections themselves are not contagious. Therefore, there is no reason to exclude a child with an ear infection from the center. It is not necessary to tell parents when other people's children have ear infections.

NOTES ABOUT THE CARE OF CHILDREN WHO HAVE FREQUENT EAR INFECTIONS:

1. Do not feed or bottle feed infants lying on their backs -- it is easier for the food or milk (with mouth germs) to run down into the Eustauchian tube in that position.

2. Be especially alert for any sign of hearing or speech problems that may show up. Refer the child to the family's health care provider or other community resources (see Chapter 9).

NOTES ABOUT CHILDREN WHO HAVE EAR TUBES:

1. An ear tube creates a hole in the eardrum so fluid and pus may drain out and fluid will not build up. It usually stays in for three to six months.

2. Since pus can drain out, water from the outside world (which has germs in it) can also run into the middle ear easily. Therefore, you must be very careful that children with tubes do not get water in their ears. This usually means no swimming unless there are special earplugs and doctor's permission.

3. Watch for any sign of any hearing or speech problems.

Remember -- Never put anything smaller than your finger into a child's ear. Do not allow the child to do so, either. *Cotton swabs should not be used.*

MONILIAL (CANDIDA) INFECTIONS (Thrush, Yeast Diaper Infections)

WHAT ARE THEY?

Monilial infections are caused by a yeast (Candida albicans) and are very common in babies and young children in diapers. In the mouth, you see white patches which look like milk curds, but which cannot be wiped off (called "thrush"). They can be anywhere inside the mouth, including the tongue, and do not seem to bother small children.

The diaper rash looks different; it starts as very red, raised, round spots. Often there will be a larger spot with surrounding smaller ones. Sometimes the spots all run together, and what you see are large areas of beefy red, raised skin which are very sore and may even bleed. Occasionally a bacteria will invade this raw skin and set up a secondary infection, with ooze or pustules.

WHO CAN GET THEM?

Anyone can! They are particularly common in diapered individuals, but adults can get thrush in their mouths or a monilial rash in their groin or other moist areas. *They are very mild infections in healthy people and almost everyone gets exposed.*

HOW DO THEY GET THEM?

The yeast organisms (a kind of fungus) are *everywhere*. Though candida can be spread from one person to another, usually people "catch it from themselves." That is to say, it is already on their body, waiting for the right conditions. When skin is wet and a little raw (such as in diaper and groin areas), the yeast can invade the skin and start spreading. Yeast infections can also occur after treatment with antibiotics.

HOW SHOULD THEY BE TREATED?

Yeast infections should be treated with appropriate medications which will be prescribed by the child's health care provider (drops for mouth, cream for the diaper area). Children never need to be sent home or excluded for these infections.

When a younger child has a diaper rash, treat it according to instructions given on page 394. If it is not much better in one to two days, have a health care professional take a look to see if it needs treatment.

TICK-BORNE DISEASES

WHAT ARE THEY?

Tick-borne diseases are several diseases which are spread to people by the bite of an infected tick. The two most common diseases in Massachusetts are Lyme Disease (LD) and Rocky Mountain Spotted Fever.

Lyme Disease is caused by a form of bacteria and is spread to people by a tiny "deer tick." In the majority of Lyme Disease cases, symptoms begin with a skin rash characterized by large, red, doughnut-shaped welts. Other symptoms are similar to those of flu and can include headache, fever, chills, muscle-aches, and stiff neck. Symptoms generally appear from one to three weeks following a tick bite.

Some patients, even if untreated, will recover from Lyme Disease without complications. However, approximately half may develop a chronic form of the disease, having repeated episodes of painful swelling in the joints. In rare cases, Lyme Disease sufferers may develop facial paralysis or heart problems. Early diagnosis is important. Treated early with appropriate antibiotics, this disease can be a mild illness and later complications can be avoided.

The second most common tick-related illness in Massachusetts is Rocky Mountain Spotted Fever. It is carried by a large and more readily seen tick called the "dog" tick. Symptoms usually begin with a rash appearing first on the wrists and ankles and spreading to other parts of the body. Other symptoms include a high fever, chills, and severe headache, and usually appear three to ten days after a tick bite. The disease can be effectively treated with antibiotics.

Tick-borne diseases have occurred in Massachusetts mainly on Cape Cod and the Islands, the northern coastal area, and the Connecticut River valley. These diseases typically begin in late May and early June and may occur until early fall.

WHO GETS THEM?

Anyone who is bitten by an infected tick can get them.

HOW DO THEY GET THEM?

Ticks are most commonly found in brushy, wooded, or tall grassy areas. They are *not* found on open sandy beaches. The "deer tick" is very small, no larger than the size of a period on a printed page. During the tick's life cycle, it may feed on an infected animal, usually a mouse. In later stages of the cycle, it clings to vegetation and is spread by direct contact to the skin of a passing animal or person. The bite of the tick can then spread the bacteria to the new host. The greatest chance of being infected is while walking barelegged through brush or tall grass, May through August.

It is important to remember that not all ticks carry Lyme Disease or Rocky Mountain Spotted Fever. Thus, a tick bite does not necessarily mean that disease will follow, and prompt removal of a tick will lessen any chance of disease transmission.

■ HOW ARE THEY DIAGNOSED?

Diagnosis of LD is based primarily on recognition of the typical symptoms of LD such as the characteristic skin rash occurring in a person who lives in or has visited one of the areas mentioned earlier. Prompt treatment of early symptoms may prevent later and more serious problems.

Atypical cases, or cases presenting with only later stage complications of LD, are difficult to diagnose. In these persons, a blood test looking for antibody to the bacteria is often helpful. DPH offers free antibody testing upon request from physicians for diagnosis of such cases. It should be noted that early in the disease, this blood test can be negative even though disease is present; only with later disease does the test become reliably positive.

The diagnosis of Rocky Mountain Spotted Fever is also based on the typical symptoms and can also be confirmed with a blood test.

■ HOW ARE THEY TREATED?

Oral antibiotic treatment is helpful early in the illness and often prevents late complications. A number of different antibiotics may be used by physicians, depending on the child's age and potential allergies.

■ SHOULD PEOPLE BE EXCLUDED?

Since tick-borne illnesses are not contagious from person to person, there is no need to exclude a child or adult from the center.

■ WHERE TO REPORT?

A diagnosis of LD, Rocky Mountain Spotted Fever, or other tick-borne illness should be reported to the local Board of Health. It is recommended that you notify all parents and staff of a case of tick-borne illness so that parents will be watchful for ticks as well.

If any child is bitten by a tick at the center, you should notify the parents of that child so they can inform their health care provider. Tell them what the tick looked like. If the child develops the symptoms described, particularly the skin rash and/or "flu-like" symptoms, parents should promptly see a health care provider for evaluation and treatment.

■ HOW CAN THEY BE PREVENTED?

The only known way to get a tick-borne disease is from an infected tick. Knowing where these ticks are found, avoiding such areas, and, if bitten, promptly removing the tick are the primary preventive measures. Persons living in or visiting Massachusetts coastal areas or islands should be aware of the following preventive measures.

People should take the following precautions during and after spending time in wooded areas along the Massachusetts coastline:

- Wear long-sleeved shirts and long pants when walking in the woods or through high grass and bushes. Keep shirttails tucked securely into pants and pant legs tucked tightly into socks. Wear sneakers or hiking boots instead of open sandals. Wear light-colored clothing. Ticks are dark in color and will be easier to see against a light background.

- Conduct daily "tick checks." The ticks are most often found on the thigh, flank, arms, underarms, and legs, and are very small. Look for new "freckles."

- If you find a tick, remove it immediately. Deer ticks are very small and hard, about the size of a pin head. They are orange-red or black depending upon their stage of growth, and prefer to attach themselves to a human host under the hair. Dog ticks are larger, ranging from one-tenth to one-quarter inch in length. They are brown and also prefer to attach themselves under the hair or on protected parts of the body.

To remove a tick, use tweezers to grip the tick body firmly and pull it straight outward. If using fingers, place a protective covering between your fingers and the tick, and wash your hands afterward. Apply an antiseptic to the bitten area.

18 Care of the Mildly Ill Child

Information

Caring for ill children in day care is a very controversial topic. The issue can be viewed from many perspectives - the child's needs, the parent's need to work, the staff's ability to cope and to give the necessary attention, the cost of serving ill children, etc. If you are interested in addressing the issue of keeping mildly ill children in day care, this chapter should help you make your decisions.

According to the American Academy of Pediatrics, Standards for Day Care Centers for Infants and Children Under Three Years of Age, "Children who are tired, ill, or upset will be given a chance to rest in a quiet area under frequent observation. Each of these children will be given a health appraisal by the regular staff and attendants. Such children need *not* be discharged home as a routine policy, but may be cared for during minor illnesss...." This statement gives us a logical starting point for looking at the care of ill children at day care.

This chapter includes the following topics:

- The Basics
- Common Minor Illnesses and Symptoms
  - Fevers
  - Colds
  - Vomiting and Nausea
  - Diarrhea
  - Rashes
  - Teething
  - Constipation
  - Sunburn
  - Heat Exhaustion and Dehydration
- Giving Medications

The Basics

SETTING POLICY

Many health policies are based upon common misunderstandings about contagion, risks to the ill child, and risks to other children and staff. Current research conducted on day care clearly shows that many ill children do not pose a health threat. In fact, keeping mildly ill children at home or isolated at the center does NOT prevent other children from becoming ill. Children shed viruses before they are obviously sick; they probably have spread the illness before they develop symptoms. Children receiving medication usually are not contagious after a day's worth of treatment.

Except in rare cases (such as active diarrhea with other symptoms, chickenpox), *there is no medical reason to exclude children* who are mildly ill or who are being treated. Obviously seriously ill children should not be in day care.

Appropriate reasons to exclude children, in addition to preventing the spread of disease, are:
- The child does not feel well enough to participate.
- The staff is not able to care for sick children in the day care setting.

Decisions must be made on a case by case basis. There is no *medical* justification for a policy which sets arbitrary cut-offs such as, "Any child with a temperature over 100° F may not remain at the center."

The basic question is: Can the child participate at day care with *reasonable comfort?* One child who has a fever and cough may still have a high energy level, good appetite, and good mood. Another child may be droopy, whiny, uninterested in any activity, and very unhappy. Every case is different and should be decided individually by parents and staff together.

In deciding whether care for mildly ill children will be provided at the day care center, here are some basic questions to ask:

- Are there sufficient staff (including volunteers) to change the program for a child/children who need some modifications such as quiet activities, staying inside, or extra liquids?

- Are staff willing and able to care for sick children (wiping runny noses, checking fevers, providing extra loving care) without neglecting the care of other children in the group?

- What are most parents' needs? Do they want this service? Do many parents fear losing their jobs because of too many absences? Does the cost of sick care cause a major hardship? Is other care available?

- Is there a small space where a mildly ill child can rest? Is there a space that might be used as a "Get Well Room" so that several children could be cared for at once? Are the children familiar with the caregiver?

- Are parents able or willing to pay extra for sick care if other resources are not available, so that you can hire extra staff as needed?

■ TO ATTEND OR NOT TO ATTEND

To decide whether or not to send a child to day care, the parent must weigh many facts such as how the child feels (physically and emotionally), the day care program's ability to serve the needs of the mildly ill child, and work/income lost by staying home. Lost work in most cases means lost income, but it may also mean the loss of a job. For low income families, this is a particularly difficult problem.

Most parents try honestly to consider all the facts and to do what is best for the child. But how does the parent decide when the facts are fuzzy? He may awaken cranky but show no signs of illness. A child may have vomited after dinner the night before but slept well and awakened cheerful. She may have an unexplained fever but seems absolutely fine. Parents need to use their best judgment very early in the morning - understandably they make mistakes sometimes. Standard rules do not necessarily solve the problem.

■ KEEP THE COMMUNICATION LINES OPEN

It is important that staff and parents communicate in the morning about any mild illness which occurred the night before. Whenever possible, this should include face-to-face contact when the child is dropped off. If there is no opportunity for personal contact, the parent should write a note. When the child leaves, it is equally important that day care staff tell the family what happened during that day. Simple information about activity level, appetite and food intake, nap time, and bowel movements can be invaluable.

One of the problems of sending sick children home for very mild illness is that some parents may not be truthful with staff. Because they want the child to stay at day care, they may not tell you what happened at home. Strict exclusion policies can "backfire" in this way.

DAILY HEALTH CHECK

When you greet the child in the morning (preferably *before* the parent has left), give the child a quick health check-up. *This does not have to be a big deal!* Just as you would notice a new haircut or a new pair of sneakers, you can be attuned to:

- activity level (sluggish, sleepy, etc.)
- breathing difficulties
- skin color
- severe coughing
- rashes
- swelling or bruises
- discharge from nose, ears, or eyes
- sores
- general mood (happy, sad, cranky)

If you have concerns about how the child looks or feels, discuss them with the parent right then. Perhaps the parent wants to take the child home. Perhaps you feel strongly that the child should leave. If the child remains, be sure to discuss how you will manage the child and at what point you would call the parent. If the child stays all day, let the parent know what happened during the day.

WHEN A CHILD APPEARS ILL

These guidelines do not refer to obvious emergencies. A seriously ill or injured child will require immediate use of emergency procedures.

If you notice that a child appears mildly ill, it is a good idea to take the child aside, encourage rest, and assess the situation. *You are not expected to diagnose illness.* Report the symptoms you have observed to the proper person in your situation - the parent, the director, the health staff person (if any) or health consultant, or the child's health provider. These procedures should be spelled out in your center's policies.

When you report the symptoms, be as specific as possible. You will want to note the following:

- symptom(s)
- when it began/how long it has lasted
- how much
- how often
- behavior change
- temperature
- other

Please see Chapter 9 for more information about health observations.

Generally, the following steps should be taken when a child becomes ill.

- Call the parent (or emergency contact).
- Based on the illness, decide if the center will care for the child.
- Keep the child comfortable.

You should have at least two emergency contact persons who are usually available to take the child home if the parent cannot be reached or is not available. Be sure these two contacts are in the child's record. It is a good idea to test their phone numbers occasionally to be sure they are current.

Common Minor Illnesses and Symptoms

Most centers provide at least temporary care of ill children. Even if you have decided on a policy of *not* providing care for ill children, there still will be times when children become sick during the day. At these times, you will have to care for the child until s/he can be picked up. The following are some guidelines for caring for ill children and keeping them comfortable.

■ FEVERS

Fever is one of the most common reasons for seeking medical care for preschool children. It appears that many parents (and the public in general, including day care providers) have unrealistic fears about fever. In fact, fevers are rarely harmful, and treatment is not always necessary.

What is Fever?

A temperature above normal can be caused by many things. Body temperature can be affected by:

- Strenuous exercise
- Time of day (temperature rises in late afternoon)
- Infection
- Environment - hot rooms, a hot day, or being bundled up
- Individual variations

There is some controversy among medical experts about what constitutes a fever; most definitions fall into the 100°-101° F oral temperature range or slightly higher for rectal. A fever of about 105° F is considered high but, in general, the height of the fever does not relate to the seriousness of the illness. How sick a child acts is what counts.

Fever is the body's normal response to infection. It may even be helpful, and there is a growing trend to treat fever less aggressively. Fever is a symptom, not a disease, and is not itself dangerous below 107°-108° F level.

Figure 59 provides instructions on how to take a temperature. You may want to consider disposable thermometer covers to make good sanitation easy. Another alternative is digital thermometers which are becoming more available and inexpensive and provide fast, accurate readings. They are also unbreakable.

When a Child Has a Fever

- Offer small amounts of liquid often. Citrus juice or milk may tend to upset the stomach. Clear liquids are best - water, flat soda, jello, broth, apple or grape juice.

- For fever of 100°-103° F, take off layers of clothing; strip the child down to underwear or diaper over 103° F.

- A moist, cool cloth to the head and body may be helpful.

- For 104° F or over, give a *tepid* (just comfortable to the wrist) "sponge down." Water evaporating from the hot skin takes body heat with it and lowers the temperature. Do *not* use alcohol rubs or wipes.

- Parents may give acetaminophen (e.g., Tylenol) or authorize you to give it with physician's orders.

Remember once again that height of fever is not necessarily related to serious illness. Many children with a temperature of 104° F or even 105° F have infections which are basically not dangerous. Infants and young children tend to run higher fevers than adults.

A DOCTOR SHOULD BE CALLED (USUALLY BY THE PARENTS) FOR ANY FEVER IN AN INFANT SIX MONTHS OF AGE OR LESS. THIS IS CRITICAL IN THE FIRST TWO MONTHS.

Children who DO have serious infections act sick. Good clues are:

- Unusual drowsiness or excessive sleep
- Loss of alertness
- "Labored" (fast or difficult) breathing
- Child looks very sick
- Child doesn't want to eat or drink
- Child is very irritable
- Child does not want to play
- Child complains about pain or cries excessively

Figure 59
How to Take a Temperature

PREPARATION

Shake the thermometer until the mercury line is below 95°-96° F. To avoid breakage, shake over something soft.

WHERE TO TAKE THE TEMPERATURE

1. In children under five years of age: axillary (armpit) temperature for screening; if axillary temperature is over 99° F (37.2° C), check with a rectal temperature.
2. In children over five years of age: oral (by mouth) temperature.

TAKING AXILLARY (ARMPIT) TEMPERATURES

1. Place the tip of the thermometer in a dry armpit.
2. Close the armpit by holding the elbow against the chest for five minutes.
3. If you're uncertain about the result, recheck it with a rectal temperature. *Axillary temperatures may not be reliable. Use for screening purposes only.*

TAKING RECTAL TEMPERATURES

1. Have the child lie stomach down on your lap.
2. Lubricate the end of the thermometer and the child's anal opening with petroleum jelly.
3. Carefully insert the thermometer about 1" (25.4 mm) but never force it.
4. Hold the child still while the thermometer is in and press the buttocks together.
5. Leave the thermometer inside the rectum for three minutes.

TAKING ORAL TEMPERATURES

1. Be sure the child has not recently drunk a very cold or very hot drink.
2. Place the thermometer tip under the right side of the tongue.
3. Have the child hold the thermometer in place with the lips and fingers (not the teeth).
4. Have the child breathe through the nose with the mouth closed.
5. Leave the thermometer inside the mouth for three minutes.
6. If the child can't keep the mouth closed because the nose is blocked, take an axillary temperature.

READING THE THERMOMETER

Determine where the mercury line ends by turning the thermometer slightly until the line appears. If this is difficult for you, practice.

CLEANING THE THERMOMETER

1. Wash the thermometer with cold water and soap. (Hot water will crack the glass or break the thermometer.) A cracked thermometer could cut the child and should be thrown away.
2. Rinse the thermometer with cold water.
3. Dry and wipe it with rubbing alcohol or immerse it in recommended bleach solution. Then let it air dry.
4. Shake down the thermometer and put it back into its case.

Adapted from Barton Schmidt, B. "Fever in Childhood."

Febrile Seizures

Four percent of children who experience fevers will have a febrile (associated with fever) seizure. Because these seizures are rarely harmful, and the first one is not preventable, they should not be cause for undue worry. Children who are likely to have such seizures are those who had one before the age of three. If a child has a history of febrile seizures and develops a fever at the center, you will want to bring down the fever quickly by doing the following:

- Remove clothing.
- Apply cool washcloths to the face and neck.
- Sponge the body with cool water.
- If you have a standing order from the child's physician and parental permission, give the appropriate dose of acetaminophen (an aspirin-substitute).

Febrile seizures are unusual and rarely have permanent effects. If a child has a seizure of any kind at the center, it probably is a febrile seizure. You should follow your center's emergency procedures for seizures.

■ COLDS

- Try to keep room temperature at or below 70° F, when possible.

- Use a cool mist vaporizer to keep the air moist during the wintertime. (Don't add anything to it, e.g., Vicks.) Do *not* use steam vaporizers.

- Raise the mattress or cot under the head for sleeping. Babies should *not* be on pillows. Put something under the mattress instead.

- Offer lots of clear liquids.

- Assist the child by helping to blow/wipe nose. *Wash your hands after.*

- Especially before eating, babies may need to have mucus removed from the nose by a rubber bulb with a plastic tip (aspirator), since they can't blow their own noses. Ask the parent to send one into day care if desired. *Do not use for any other baby.*

- Let children rest. They may need less strenuous activities or more sleep.

- Don't force the child to eat.

VOMITING AND NAUSEA (FEELING SICK TO THE STOMACH)

- Stop solid food.
- Offer clear liquids - water, flat cola or ginger ale (shake bottle or stir in glass to remove the bubbles), jello, broth.
- Offer liquids in very small amounts: 1-2 ounces (or 2-4 tablespoons) every fifteen minutes.
- Sometimes popsicles or ice chips can be soothing.
- *Do not force child to drink.*
- Parents will want to give only clear liquids for twenty-four hours -- go slowly for next day on solids or until completely recovered.
- If child begs for food, give plain crackers, dry plain cookies or toast, or rice cereal.
- Spitting up is not vomiting.
- In case of repeated vomiting, call the parent.
- *When the baby is under six months, the parent should call the doctor.*

DIARRHEA

One loose stool does not mean that a child has diarrhea. However, a child with even one loose stool should be watched carefully and precautions taken. *DIARRHEA is:*

An increase in the number of stools over what is normal for that person.
AND
Stools which are unformed (they are loose/watery and take the shape of the container they are in).

(Exception: Breast-fed babies have stools which are *normally* loose.)

Children with diarrhea alone (that is, without other symptoms) *do not need to be sent home or excluded* if the center can take appropriate precautions. A child with both diarrhea and fever or other symptoms of disease should be sent home. (See section on Infectious Diarrhea in Chapter 17 for details.)

If the child with diarrhea stays at the center, or if the child is still at the center awaiting pick up by parents, the following guidelines for care should be followed.

- Offer clear liquids (See Vomiting section)

  Infants: 1-2 ounces at a time, every fifteen minutes or so.

  Preschool children: 2 to 4 ounces at a time, every fifteen minutes or so.

- Avoid whole milk and milk products except cheese.

- If the child acts hungry, offer foods such as rice, oatmeal, crackers, toast, mashed banana, popsicles.

When the Baby is Under Six Months, the Parent Should Call the Doctor.

Although vomiting and diarrhea are generally considered mild illnesses, they can sometimes lead to *dehydration,* a more serious condition. Dehydration is an excessive loss of water and minerals from the body through stools. *Watch for these symptoms: decreased frequency and amount of urinating; few or no tears; a sticky or dry mouth; and thirst. If dehydration is suspected, the parent should call the doctor.*

RASHES

General Information

Although rashes are usually not symptoms of serious illness, people tend to worry about them because the skin is seen so easily. Although you will not diagnose or decide on treatment for rashes, you should supply parents with detailed information for them to report to the physician who will want to know:

- Is the rash red (blood colored) or pink?

- Is the skin warm to the touch?

- Is the rash raised or flat, pin-prick size or blotches, dry or blistering?

- Where on the body was the rash first noted? How has it changed since it was first noted?

- Has the child had an injury or exposure to infection, drugs, or chemicals associated with developing the rash?

- Does the child look or act sick in any other way?

- Has the child had this rash before?

- Has the child been in contact with someone who has this rash?

Solid red, warm areas which are spreading may be caused by infection. Many infections which affect the whole body are associated with rashes. (Please refer to Infectious Diseases, Chapter 17, for details.)

Many rashes look alike; sometimes even the doctor cannot make a definite diagnosis. The best clues are any other symptoms along with the rash and knowing what's "going around."

Although most rashes are more toublesome than dangerous, there is a group of rashes associated with severe and life-threatening illness. These rashes look like little blood spots or bruises under the skin. Children may develop little blood spots around their faces and necks from crying hard or vomiting; but when this rash appears elsewhere on the body, without being explained by trauma, a health professional should be called immediately. The rashes from spontaneous bleeding into the skin signal serious disturbances in the body's bleeding control systems. Spontaneously appearing blood red spots or bruises without trauma should be addressed as a medical emergency. Fortunately, these illnesses occur infrequently.

Good skin health practices include:

- water rinsing to remove food and urine

- using soap only when needed to remove soil, followed by thorough rinsing with plain water

- avoiding prolonged exposure to wetness or stool

- wearing the least amount of clothing needed to keep warm

In general, you should avoid special skin products unless requested by a health professional. Many of the products tend to be heavily perfumed, and in fact may *create* skin problems (e.g., dry skin, diaper rash). Some creams are very difficult to wipe off. Even chemicals in premoistened,disposable wipes can cause trouble. *The less done to the skin, the better.*

Diaper Rash

Diaper rash is basically a burn to the skin from the ammonia which is formed in the breakdown of urine by the bacteria on the skin. In order to care for diaper rash, you should take the following steps.

1. Treat the burn itself. When a rash is present:

    - Leave the baby without diaper and plastic pants when in his/her crib during naps.

    - A cool sitz bath may help (at least fifteen minutes to give time for deep cooling and contraction of blood vessels).

2. Neutralize ammonia and make it hard for the bacteria on the skin to grow.

    - Put vinegar (2-3 tablespoons) in bath. Vinegar is a mild acid which works against the ammonia and prevents bacteria growth. Bathing also cuts down need for rubbing the child's sore bottom.

    - To make urine more acid, have the child drink acid fruit juice -- cranberry is good (citrus less effective).

    - Bacteria do not grow well in diluted urine - increase child's intake of liquid.

3. Suggest to parents that if a diaper is used at night, they may do the following to keep the urine away from the skin:

    - Use zinc ointment (e.g., Desitin) or petroleum jelly (e.g., Vaseline). Make sure the child is clean and dry first.

    - Use a second paper diaper without plastic backing as a liner for regular paper diaper at night.

4. Stools contain broken down bile, which is like a detergent and irritating, so change the child right away and wash child's bottom well with soap and lukewarm water. For a small infant, this rinsing can easily be done over the sink. If you do this, you must wash and disinfect the sink.

    - Do not run water from the tap directly onto an infant's skin.

    - Use your hand to be sure that a sudden surge of hot water from the tap cannot scald the child.

5. *Avoid talcum or baby powder; it can be inhaled into the lungs.*

Heat Rash

Heat rash is also known as prickly heat. Small red bumps usually occur on the neck, upper chest, and back of the head.

- Do not overdress child.
- Wash and dry, especially between skin creases.
- Sponge and dry the area with cool tap water often.
- Baby powder is NOT helpful.

TEETHING

Teething may be painful and cause children to be cranky.

- Provide something hard and/or cold to bite on (e.g., a very cold large carrot, a teething biscuit, a safe teething ring toy).

- Rub gums with *clean* finger or ice cube. (Wash your hands before and after doing this.)

CONSTIPATION

Constipation is present when the child has excessively hard bowel movements which cause pain or are accompanied by mucus or blood. A child who has infrequent bowel movements is not constipated if the stool appears normal when it is passed. Normal bowel patterns vary from twice a day to once or twice a week. When the stool is hard, it usually means the child is not drinking enough fluid to keep up with the body needs or does not have enough roughage (fiber) in his/her diet. If a child is constipated, be sure that you discuss the problem with the parents so that you can decide what to do.

To help reduce the hardness of stools, begin by increasing fluid intake, especially juices. Have the child drink at least 32 ounces (four medium glasses) of fluid each day divided into frequent, small amounts. Try to have the child eat fruits such as apricots, pears, peaches, and prunes - fresh, dried or canned - twice a day. Eating bran cereals, celery and carrots will also help, because they have fiber which holds fluid in the intestine to keep stools soft. Leafy, green vegetables such as lettuce, spinach, and greens provide roughage. Limit binding foods such as bananas, apples and dairy products. If these measures do not work, consult a doctor.

SUNBURN

Young children are more likely to get sunburned than adults. Certain areas such as the face, shoulders, and back of knees are more likely to burn than other areas. For children who are susceptible to burn, these areas should be protected with one of the many sun-blocks (provided by child's parents). For children in day care, parental consent is required before any skin treatment product is used on a child. Suntan or sun screen lotions should not be applied to broken skin.

Because it takes several hours for a sunburn to show, watching for reddening of the skin is an undependable way to tell when a child has been in the sun too long. By the time you notice any change, it is too late. The sun's rays are most intense from 11 a.m. to 2 p.m. Reflections of the sun's rays from water and sand increase sunburn dangers. Cloudy days can fool you; clouds won't stop the sun from burning. *It is a good idea on most summer days to plan for playtime in the shade, frequent fluid intake, and skin cooling.*

When a child has a sunburn, medications should not be applied to the skin without a doctor's recommendation. There is no *cure* for sunburn, but the pain and itching that accompany a burn can be treated with a cool bath or compresses applied three or four times a day for 10 to 15 minutes at a time. Severe burns are accompanied by intense pain, blistering of the skin, nausea, chills, and fever. These symptoms require a parent to consult the physician.

■ HEAT EXHAUSTION AND DEHYDRATION

After prolonged exposure to high temperatures and high humidity, children may have one or more symptoms of heat exhaustion: pale and clammy skin, heavy sweating, fatigue, weakness, dizziness, headache, nausea, muscle cramps, vomiting, or fainting.

The best preventive measures are to keep children well hydrated and regularly cooled off. Frequent small amounts of clear liquids help restore fluids which the body has lost through evaporation. Good, sanitary cooling can be achieved by having children play under a sprinkler or by using cool water on paper towels to remove the perspiration and oil from their skins.

Thirst is not a good indicator of dehydration, because a child can become dehydrated before becoming thirsty. Frequency of urination and color (concentration) of the urine are better indicators of fluid needs. Normally, the urine of a child should be pale yellow or colorless and urination should occur every two or three hours.

On warm days, water should be readily available and children should stop to take a drink before and after vigorous play, or at least about every two hours throughout the day. Dehydration can thus be prevented.

When a child (or adult) has symptoms of heat exhaustion, the first thing to do is to move the person to a cool and shaded area.

Giving Medication

Almost all children, at one time or another, need medication. It is reasonable to expect that parents will ask you to give medications either for a chronic (ongoing) problem (e.g., asthma) for a mild illness (e.g., antibiotics for an ear infection) or on an "as needed" basis (e.g., decongestant for stuffy nose).

Day care providers are NOT required to give medication to children. If you do not want to be responsible for giving medication, you may help parents to set up a schedule for giving medications only at home, if possible. Parents should consult with their doctor; sometimes medicines can be given in different forms (liquid, pill, capsule, etc.) and/or a varying number of times per day (e.g., morning and bedtime vs. three times per day). If a parent works near your day care setting, you may ask the parent to come during the day to give the medication, if necessary. If you do decide to give children medication, you must follow the Office for Children regulations [102CMR 7.07(17)] listed here.

"*Administration of Medication:* The licensee shall not administer prescription or nonprescription medication to a child without the written order of a physician (which may include the label on the medication) which indicates the medication is for the specific child.

- No medication, whether prescription or nonprescription, shall be administered to a child without written parental authorization.

- The licensee shall keep a written record of the administration of prescribed medication to children which includes the time and date of each administration, the name of the staff member administering the medication, and the name of the child.

- The licensee shall keep all medicine labeled with the child's name, the name of the drug and the directions for its administration and shall dispose of, or return to the parent(s) any unused medication."

Below are some additional practical guidelines for medications.

- All staff who are responsible for giving medications should be trained in specific procedures by a physician or nurse.

- Have parents ask the pharmacist filling a prescription to give them a small extra *labeled* bottle to bring to day care.

- Keep a medicine log sheet posted where you give it to the child (e.g., on refrigerator) so you won't forget to write down the exact time and date. Put this in the child's folder after the course of medication ends.

- Be sure you have very specific instructions about how the medicine should be given (e.g., before or after meals, with a full glass of water after the medication, tilting head). Most prescription labels do not have this information.

- Learn the possible side effects of the medication and inform the parent immediately if you observe any. Do not give more medication without the approval of the parent or child's physician.

- Always read what the label says about storage; some drugs need to be refrigerated.

- *ALWAYS READ THE LABEL CAREFULLY BEFORE YOU GIVE ANY MEDICINE; BOTTLES OFTEN LOOK THE SAME.* Be sure that the child's name is on that bottle, since often several children may be taking the same medicine. As an extra precaution, some centers put medication in a bag labeled with the child's name in large letters.

- Keep medicines in a locked cabinet or out of reach of children. (Don't forget medicines in the refrigerator.)

- Be sure that you do not leave medicine out without adult supervision, e.g., when you answer the telephone or leave the room. Put it away first, or take it with you. A child can take an overdose in seconds.

- Never refer to medicine as "candy" or something else children like. They may try to get more of it when unsupervised.

Figure 60 shows a sample medication log form which is appropriate for day care centers.

Figure 60
Sample Medication Form and Log

Name of Child ________________ Date ________ Room _____
Name of Medication ________________ Date prescribed ________
Date last dose due ________

FOR PARENT TO COMPLETE:

I, ________________ (parent or guardian) give permission to ________________ (name of authorized day care staff) to administer ________ (dose) of ________________ (name of medication) to my child, ________________ (name of child) at approximately ________________ (time[s] dose due) on ________________ (dates and days) for ________________ (reason for medication).

Possible side effects to watch for with this medication include: ________________

The name and phone number of the prescribing physician: ________________

FOR STAFF TO COMPLETE:

Is the permission form (above) completed? ________
Is the medication in a safety cap container? ________
Is the original prescription label on the medication container? ________
Is the name of child given above on the container? ________

Is the date on prescription current (within the month for antibiotics and within the expiration date for medications which are so labeled; within the year otherwise? ________

Is the dose, name of drug, frequency of administration given on the label consistent with parental instructions given above? ________

MEDICATION CAN BE ADMINISTERED ONLY IF THE ANSWERS TO ALL QUESTIONS ABOVE ARE "YES."

MEDICATION ADMINISTRATION RECORD

DAY	*DATE*	*DOSE*	*STAFF SIGNATURE*

Health in Day Care: A Manual for Health Professionals American Academy of Pediatrics, 1987. Prepared by Susan S. Aronson, M.D.

References

Anerican Academy of Pediatrics. Committee on Infant and Preschool Child. Recommendations for Day Care Center for Infants and Children. Evanston, IL: American Academy of Pediatrics, 1973.

Aronson, S.S. Medication administration in child care. Child Care Information Exchange, January, 1985, pp. 26-29.

Aronson, S.S. Summer safety. Child Care Information Exchange, August, 1984, pp.13-15.

Aronson, S.S. What to do about rashes. Child Care Information Exchange, May, 1985, pp. 26-28.

Boston Children's Medical Center and Feinbloom, R.I. Child Health Encyclopedia: The complete guide for parents. New York: Delacorte Press/Seymour Lawrence, 1975.

Nelson, H.M. and Aronson, S.S. Health Power: A blueprint for improving the health of children. New York: Westinghouse Health Systems, 1982.

Rx for Administering Medication. Preschool Perspectves 1:7-8, (September, 1984).

Schmidt, Barton B. Fever in Childhood. Pediatrics 74 (Supplement): 929-936 (1984).

19 Sick Child Care Models

Introduction

There are a number of ways to provide sick child care for preschool children. These include adequate rest, appropriate diet, medications as ordered, and appropriate physical and emotional support.

In some cases, personnel policies allow a parent to care for a sick child at home; paid time, within limits, is given to the parent to support this option. Employers should be encouraged to develop flexible policies which consider the fact that family illness is unavoidable. However, when care by the parent is not possible, there are a variety of substitute sick child care models.

Since every child is bound to become sick at times, it is crucial that options for sick child care be discussed at the time the child is first enrolled at the center. Many parents have not thought ahead as to what they will do if the child cannot attend the center due to illness.

This chapter will begin with general considerations for providing sick child care in any setting. Specific models will be described briefly to acquaint you with some of the options for care. If you are interested in additional information about sick child care, see the references listed at the end of the chapter.

General Guidelines

There are some practices of care which relate to all models of sick child care. Some basic needs to consider are:

- training for providers in first aid, sick care, infectious diseases, and child development. The provider should know CPR.
- careful hygiene of the sick care area
- emergency procedures
- plans for contacting parents
- medical backup

- a sink and bathroom nearby
- use of disposable towels and tissues
- materials for quiet activities for the child
- a locked or "out of reach" cabinet for medications
- a cool air vaporizer, for wintertime
- a method for laundering such items as bedding

Sick Care in Day Care Centers

The issue of sick child care is an emotionally charged one. It challenges our very basic notions about caring for children and the fine line between parent responsibilities vs. staff responsibilities. Nevertheless, the issue will not go away. While it may be dificult to handle mildly ill children, we urge you to consider some of these models as a way to meet this very real need for children and families.

■ THE CHILD'S OWN CENTER

"Get Well" Area of the Classroom

This method requires a small area of the classroom where a child can rest or play quietly. It may be as simple as a cot in a quiet area. The area needs to be in view of an adult for supervision and frequent contact. The child may choose to participate in some group activities, while using the "get well" area as a home base. Ideally, a volunteer or "floating" adult will look after the child as needed, stay indoors when the others are outside, and provide additional physical and emotional support.

"Get Well" Room

This model could be considered when a small separate space is available. An adult needs to be present at all times - one adult to no more than two or three sick children is an ideal ratio. The room should be equipped with a comfortable resting place; quiet activities (e.g., reading, playing records, and table toys); and easy means for providing food, liquid, and medication. You may want to have a regular volunteer or extra staff person on call. This person may be someone who also substitutes for staff. According to OFC regulations, this person must be teacher-qualified if s/he is alone with children.

The advantage of both of these options is that ill children can be cared for in their familiar environment by adults they already know and trust.

- SICK CHILD CARE CENTERS

This model is a separate facility specifically designed for ill children. The center may be freestanding, or in some cases, sponsored by a day care center. Since the sick child care center is separate, the children may not be familiar with the staff, the environment, or other children. It is important, therefore, to visit before a child becomes ill so that the child has a positive introduction to the program. This type of medical infirmary for ill and recovering children may serve the physical needs of children very well, but it is least likely to support the child emotionally, since both the environment and the staff are unfamiliar. The center may also be far from home which would mean a long, uncomfortable ride for a sick child.

At present, there are no specific Office for Children regulations for sick child care centers.

Sick Care in Family Day Care Homes

- A FAMILY DAY CARE HOME THAT A CHILD ATTENDS REGULARLY

Some children attend both a day care center and family day care for part of the day. This option has the advantage that the child is cared for in a familiar environment. Since the family day care setting is often flexible and informal, a mildly ill child may be included if the provider is willing and able to care for minor illnesses.

- A FREESTANDING FAMILY DAY CARE HOME SERVING ONLY SICK CHILDREN

This family day care home is designed specifically to care for ill children. This home could be separate from any agency. While this set up could work very well, no regulations or administrative support exists to monitor the care.

- "SATELLITE" HOMES LINKED TO A DAY CARE CENTER OR AGENCY

In this model, the day care center or agency (e.g., a hospital) would be responsible for placement of children, training of providers, and payroll. The providers could be used as substitutes in the day care center when they are not giving sick care. Because of this linkage, children can become familiar with the providers before being cared for in the home environment. Because all of the children come from the same day care center, all the ill children at this family day care home come from the same germ pool; therefore, new illnesses are rarely passed around.

Remember, all family day care homes, including these sick child care options, must be registered by the Office for Children.

Sick Care Services at Home

CARE BY KNOWN ADULTS

The child may be cared for in his/her own home by an adult such as a family member, friend, or family babysitter. This situation is probably one of the most comfortable options for the child both emotionally and physically. The adult should be informed about the nature of the illness and given complete instructions for care.

INFORMAL NETWORK OF CAREGIVERS

The day care center could keep a list of all available adults who wish to care for ill children at the child's home. Especially good resources are students (in early childhood or health fields), substitute staff persons, and older or retired persons. These caregivers should be given detailed instructions for care.

HOME HEALTH AGENCIES/BABYSITTING SERVICES

Some home health agencies have workers who care for ill children. This service tends to be quite expensive but has the advantage of providing reliable and trained staff. Some communities have developed specific sick child care programs for preschool children with the help of public funding or employer support to help pay the high fees.

References

Fredericks, B., Hardman, R., Morgan, G., Rodgers, F., A Little Bit Under The Weather. Boston: Work/Family Directions, Inc., 1986.

Mohlabane, N., "Infants in Day Care Centers: In sickness and in health." (A Master's Thesis on Sick Child Care.) Oakland, CA: Bananas Child Care Information Referral and Parent Support, undated.

Parents in the Workplace. Sick Child Care: A problem for working parents and employers. Minneapolis: Greater Minneapolis Day Care Association, July, 1983.

Appendix 1

Outline for Writing Health Policies

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
HEALTH RECORDS FOR CHILDREN				
1. Contents of health record (include forms used)				
a) intake form/developmental health history				
b) physical examination/ immunization status				
c) injury reports				
d) medicine log				
e) screening/assessment results				
f) parent permission slips				
g) information about chronic disease/special needs				
2. Screenings				
3. Review/update of health record				
4. Communication system among health providers, staff, parents				
5. Protecting confidentiality				

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
HEALTH CARE/HEALTH RECORDS FOR STAFF				
1. Requirements for pre-employment and periodic health exams (including who pays)				
2. Contents of health record a) health history b) immunization status c) results of health exam d) record of injuries at work				
3. Staff exclusion policies				
4. Plan for sick leave, breaks and substitutes				
ROLE OF HEALTH CONSULTANT				
1. Tasks of the consultant				
2. Back-up resources for special situations, e.g., outbreak of infectious disease				
3. Fee arrangements, if any				
DAILY ADMISSION				
1. Greeting child/ observation of possible health problems				
2. Communication system between staff and parents (e.g., nap, food intake, bowel movements, mood)				

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
MANAGING THE ENVIRONMENT				
1. Method for checking the center and correcting safety hazards, lighting, heating, ventilation and maintenance problems				
2. Supervision required in classroom/ playground				
3. Safe storage of poisonous and hazardous materials				
4. Requirements for handwashing by staff/children				
5. Disposal of contaminated items and trash				
6. Changing of diapers/clothing				
7. Arranging for soiled clothing/rest items to be properly laundered				
8. Cleaning the center, including bathrooms, kitchen, play areas, toys; schedule for cleaning; cleaning agents				
9. Cleaning and storing individual rest equipment				
10. Purchase of safe toys, equipment, arts and crafts materials				

Appendix 1 (cont.)

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
CARE OF ILL CHILDREN				
1. Evaluation of symptoms				
2. Contacting parent(s) or emergency person				
3. Deciding whether child will remain in day care				
4. Getting medical advice, if needed				
5. Providing care for ill children				
GIVING MEDICATIONS				
1. Getting written parent permission with doctor's order				
2. Storage				
3. Giving medications				
4. Recording medicines given				
5. Parent/staff communication (e.g., side effects, child's reactions)				

Appendix 1 (cont.)

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
EXCLUSION OF ILL CHILDREN				
1. Reason for excluding ill children				
2. List of illnesses/symptoms of children to be excluded				
3. Deciding the child must leave/not attend day care				
4. Contacting parent(s) or emergency person				
MANAGING OUTBREAK OF INFECTIOUS DISEASES				
1. Identification of the illness				
2. Specific measures to prevent spread				
3. Notification of other parents/ local health department				
4. Center's treatment plan, when necessary (e.g., Rifampin for meningococcus)				
5. Experts to be consulted				
MANAGING EMERGENCY ESCAPES				
1. Posting emergency plan near all telephones and exits				
2. Emergency contact persons				

Appendix 1 (cont.)

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
MANAGING EMERGENCY ESCAPES (cont.)				
3. Evacuation procedures including special considerations for infants and toddlers and non-walking persons				
4. Staff responsibilities				
5. Regular evacuation drills				
6. Management of injuries, if necessary				
MANAGING INJURIES				
1. Who is responsible for giving first aid				
2. Assessment of injuries				
3. First aid procedures				
4. Type and location of first aid supplies				
5. Notifying parents				
6. Emergency transportation				
7. Writing/filing injury report				
8. Special field trip procedures (e.g., portable first aid supplies, copies of emergency forms, safety precautions, additional adults)				
9. Reviewing injury reports to identify hazards.				

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
TRANSPORTATION				
1. Requirements for safety restraints for children and adults				
2. Safety procedures for field trips				
3. Procedures for safe arrival and departure, including escorting children to and from vehicles				
4. Who is allowed to drive for the program				
5. Driver training				
6. Late arrival/pick up				
NUTRITION/FOOD PREPARATION AND HANDLING				
1. Getting and using information about child's usual feeding schedule, food habits vitamin or mineral supplements, food allergies, cultural eating habits				
2. Managing food services, including food ordering, menu planning, food preparation and food storage				
3. Transporting/storing perishable foods sent from home to center				
4. Special food procedures for infants				

Appendix 1 (cont.)

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
DENTAL 1. Daily teeth/gums cleaning procedure 2. Storage of toothbrushes 3. Dental first aid procedures 4. Fluoridation program, if appropriate				
HEALTH CURRICULUM FOR CHILDREN 1. Concepts/topics to be taught 2. Methods for integrating health into overall curriculum				
STAFF/PARENT HEALTH TRAINING 1. Methods (e.g., workshops, newsletters) 2. Process for assessing needs 3. Possible topics to be covered				

Appendix 1 (cont.)

	WHO IS RESPONSIBLE?	WHAT IS THE PROCESS?	WHEN WILL IT BE DONE?	OTHER INFORMATION
RESOURCE AND REFERRAL 1. Procedures for reporting suspected child abuse or neglect 2. Procedure for referrals for screening, diagnosis, treatment, or supportive services 3. Resources commonly used for training, curriculum development, screening, treatment, supportive services, medical consultation, financial assistance, etc.				

Appendix 2

Office for Children Health Care Policy Form

Section 7.07 (14) requires a written health care policy statement provided to each staff member and posted near a telephone and including the following:

A. HEALTH CARE CONSULTANT: ______________________ Telephone: __________

Address: ______________________

B. EMERGENCY TELEPHONE NUMBERS:

Fire Dept: __________

Police: __________

Rescue: __________

Poison Prevention Center: __________

C. HOSPITAL(S) UTILIZED FOR EMERGENCIES:

Name: ______________________ Telephone: __________

Address: ______________________

Name: ______________________ Telephone: __________

Address: ______________________

D. EMERGENCY PROCEDURES (Step by step including transportation method and notification of parent.)

____

____

____

____

____

E. EMERGENCY PROCEDURES IF PARENTS CANNOT BE CONTACTED:

____

____

____

____

F. PROCEDURES FOR UTILIZING FIRST AID EQUIPMENT

1. Location of First Aid Kit: ____________________

2. Location of First Aid Manual: ____________________

3. First Aid is administered by: ____________________

____

4. The First Aid Kit is maintained by: ____________________

5. Contents of the First Aid Kit [7.07 (16) (b)]

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

G. EMERGENCY PLAN FOR EVACUATION OF THE CENTER:

Are separate evacuation plans posted for each classroom area? ____________

Who leads the children out of the building? ____________________

____

Who checks for stragglers? ____________________

Who is responsible for assuring the number of children in attendance equals the number of children safely evacuated?

____

When are fire drills conducted? (exact number of drills and dates)

____

____

____

H. DESCRIBE PLAN FOR DISPENSING MEDICATION (PRESCRIPTION AND NON-PRESCRIPTION) AND THE PLAN FOR THE RECORDING OF THE DISPENSING OF MEDICATION [see 7.07 (17)]:

I. PLAN FOR THE CARE OF MILDLY ILL CHILDREN IN THE CENTER:

J. PROCEDURES FOR IDENTIFYING AND PROTECTING CHILDREN WITH ALLERGIES:

K. PROCEDURES FOR REPORTING SUSPECTED CHILD ABUSE OR NEGLECT TO THE DEPARTMENT OF SOCIAL SERVICES INCLUDING TELEPHONE NUMBERS:

L. LOCATION FOR THE STORAGE OF:

Toxic Substances:

Medication:

Hazardous Items:

Appendix 3

Department of Public Health Programs and Services

Central Offices: 150 Tremont St., Boston, MA 02111 (617) 727-2700

DIVISION OF FAMILY HEALTH SERVICES:

Preschool Health Program	727-0944
Statewide Childhood Injury Prevention Program (SCIPP)	727-1246
Massachusetts Passenger Safety Program	727-1246
Vision and Hearing Screening Program	727-0944
WIC (Women, Infants and Children)	727-6876
Perinatal/Genetics Services Unit	727-5121
Women's Health Programs, including Resource Center for the Prevention of Family Violence and Sexual Abuse	727-0941
Case Management Services Unit, Boston Regional Office Other areas - call appropriate regional office	727-8925
Community Services for Handicapped Children (Home Care Services, Medical Review Team, Training and Respite, Camperships)	727-5822
Early Childhood Development Services (Early Intervention, Integrated Preschools, Training and Outreach, Developmental Day Care)	727-5089
Office of Nutrition Services	727-9283

Appendix 3 (cont.)

OTHER DIVISIONS AND PROGRAMS:

Childhood Lead Poisoning Prevention Program (CLPPP) State Laboratory 305 South Street Jamaica Plain, MA 02130 OR: call appropriate regional office	(617) 522-3700 Ext. 175
Division of Communicable Disease Control State Laboratory (see above) OR: call appropriate regional office	522-3700 x420 or 727-2686 x420
Division of Dental Health 150 Tremont Street, 2nd Floor	727-3150 727-0732
Divisions of Alcoholism and Drug Rehabilitation 150 Tremont Street, 6th Floor	727-1960
Center for Health Promotion and Environmental Disease Prevention 150 Tremont Street, 7th Floor	727-2662

REGIONAL HEALTH OFFICES

You can call a Regional Health Office for information about any of the following MDPH services and programs. If a service is not listed, you should call the appropriate number in our central offices.

Division of Family Health Services

Clinic Services for Handicapped Children
Case Management Services for Multiple-Handicapped Children
Family Health Services Coordinator
(General information about Divisional activities and contracted programs available in the Region.)

Other Services:

Childhood Lead Poisoning Prevention Program (CLPPP)
Immunization Requirements/Communicable Diseases
Public Health Nursing Consultation
Sanitation/Health Codes
Tuberculosis Control
Health Promotion Coordinator

Appendix 3 (cont.)

WESTERN REGIONAL HEALTH OFFICE
Amherst Office..(413) 586-7525
23 Service Center or 1-800-445-1255 (toll free
Northampton, MA 01060 from 413 area code only)

Pittsfield Office..(413) 443-4475
246 North Street
Pittsfield, MA 01201

CENTRAL REGIONAL HEALTH OFFICE
Rutland Heights Hospital..................................(617) 886-4711
Maple Avenue or (617) 727-1910
Rutland, MA 01543

NORTHEAST REGIONAL HEALTH OFFICE
Tewksbury Hospital..(617) 851-7261
East Street or (617) 727-7908
Tewksbury, MA 01876

SOUTHEAST REGIONAL HEALTH OFFICE
Lakeville Hospital..(617) 947-1231
Human Services Building or (617) 727-1440
Lakeville, MA 02346 Ext. 590

BARNSTABLE COUNTY
(SHC Clinic Services are provided
under a contract with the Division
of Family Health Services)
Barnstable County Health Dept..........................(617) 362-2511
Barnstable County Court House Ext. 331
Barnstable, MA 02360

PLEASE NOTE: We do not have a Greater Boston Regional Office for any services except Case Management. Boston area questions should be addressed to the main central office numbers.

SELECTED CONTRACTED SERVICE PROVIDERS (as of January, 1988):

EARLY INTERVENTION PROGRAMS

Anne Sullivan Center E.I.
Tewksbury Hospital
Tewksbury, MA 01876
(617) 851-3261

Brighton Early Intervention
77 Warren Street
Brighton, MA 02135
(617) 783-3141

Cambridge/Somerville MHC
Early Intervention Program
12 Maple Street
Cambridge, MA 02139
(617) 491-0600

Cape Ann Early Intervention
Program
225 Cabot Street
Beverly, MA 01915
(617) 921-1182

Cape Cod Early Childhood
Intervention Program
83 Pearl Street
Hyannis, MA 02601
(617) 362-4222

Children's Health Program
284 Main Street
Great Barrington, MA 01230
(413) 528-9311

Concord Area E.I. Program
Community Agencies Building
Concord, MA 01742
(617) 369-3524

Danvers-Salem E.I. Program
287 Lafayette Street
Salem, MA 01970
(617) 745-2440

Early Intervention Program
85 Main Street, Suite 628
North Adams, MA 01247
(413) 664-4541

Early Intervention Program
142 Crescent Street
Brockton, MA 02401
(617) 586-5977

E.I. Program of Bay Cove
Human Services, Inc.
1392 Dorchester Avenue
Dorchester, MA 02122
(617) 825-6900

E.I. Program of Dorchester
Counseling Center
591 Morton Street
Dorchester, MA 02124
(617) 436-8616

Fall River E.I. Program
636 Rock Street
Fall River, MA 02720
(617) 675-5778

First Program
574 Main Street
Weymouth, MA 02190
(617) 331-2533

Harbor Area E.I. Program
25 Staniford Street
Boston, MA 02114
(617) 727-7231

Haverhill/Newburyport
Early Intervention Program
491 Main Street
West Newbury, MA 01985
(617) 363-5553

Herbert Lipton CMHC
Early Intervention Program
545 Westminster Street
West Fitchburg, MA 01420
(617) 343-6957

Infant Toddler Intervention
Program
25 Washington St.
Westfield, MA 01085
(413) 568-3942

Kennedy-Donovan Center
553 Main Street
Hanson, MA 02341
(617) 294-8064

Kennedy-Donovan Center
80 Rivet Street
New Bedford, MA 02744
(617) 992-4756

Kennedy-Donovan Center
Lewis School, Mechanic Street
Foxboro, MA 02035
(617) 543-2542

Marlboro Early Intervention
31 Spring Hill Road
Marlboro, MA 01752
(617) 481-2100

Middlesex Child Development Center
651 Franklin Street
Framingham, MA 01701
(617) 620-1442

Mystic Valley E.I.
15A High Street
Winchester, MA 01890
(617) 729-3094

New England Memorial Hospital
Early Intervention Program
5 Woodland Road
Stoneham, MA 02180
(617) 665-1740

Pediatric Development Center
400 Columbus Avenue Ext.
Pittsfield, MA 01201
(413) 349-4537

Professional Center for
Handicapped Children
Early Intervention Program
32 Osgood Street
Andover, MA 01810
(617) 475-3806

Early Intervention Program
Newton Guidance Clinic
64 Eldredge Street
Newton, MA 02158
(413) 969-4925

REACH Program
Vernon St. Children's Center
Northampton, MA 01060
(413) 586-8692

Roxbury Children's Center
185 Dudley Street
Roxbury, MA 02119
(617) 442-3167

SNCARC E.I. Program
Adams Street
Medfield, MA 02052
(617) 359-5546

South Central E.I. Program
Harrington Hospital
100 South Street
Southbridge, MA 01550
(617) 765-9771

Step One E.I. Program
67 Parkingway
Quincy, MA 02167
(617) 770-7720

Taunton E.I. Program
1 Hill Street
Taunton, MA 02780
(617) 823-5327

United Cerebral Palsy Assn. of the
North Shore - Infant Devel. Program
103 Johnson Street
Lynn, MA 01902
(617) 593-2727

Univ. of Mass. Medical Center
Child Development Center
E.I. and Family Support Program
55 Lake Avenue North
Worcester, MA 01605
(617) 856-4204

Valley Child Development Center
145 West Street
Milford, MA 01757
(617) 478-7752

Valley Infant Development Service
31 Park Street
Springfield, MA 01103
(413) 739-3954

Waltham E.I. Program
Hope Avenue
Waltham, MA 02154
(617) 647-6564

North Central E.I.
259 Green Street
Gardner, MA 01440
(617) 632-9400

West Ros Park E.I. Program
780 American Legion Highway
Roslindale, MA 02131
(617) 325-6700

INTEGRATED PRESCHOOLS

Anne Sullivan Center
Tewksbury Hospital
Tewksbury, MA 01876
(617) 851-6762

Baylies Beginning Center
3 Randolph Street
Canton, MA 02021
(617) 828-2440

East Mountain Center
91 East Mountain Road
Westfield, MA 01085
(413) 737-6792

Integrated Pre-School
Cape Cod Child Development
83 Pearl Street
Hyannis, MA 02601
(617) 775-6240

HIGH-RISK INFANT COMMUNITY-BASED SUPPORT PROGRAMS

Visiting Nurse and Health Services In Franklin County, Inc.
50 Miles Street
Greenfield, MA 01301
(413) 774-2302

Providence Hospital/Elm St.
210 Elm Street
Holyoke, MA 01040
(413) 536-7496

Pernet Family Health Service
237 Millbury Steet
Worcester, MA 01610
(617) 755-1228

Visiting Nurse Association of North Shore
5 Hutchinson Drive
Danvers, MA 01923
(617) 374-7473

Upham's Corner
500 Columbia Road
Dorchester, MA 02125
(617) 436-2923

Greater New Bedford CHC
1204 Purchase Street
New Bedford, MA 02740
(617) 992-6553

Quaboag Valley VNA
103 Fairview Street
Palmer, MA 01069
(413) 283-9715

HBI Program
Boston City Hospital
House Officer's Building, Room 313
818 Harrison Avenue
Boston, MA 02119
(617) 424-5355

Brockton Visiting Nurse Association
300 Battles Street
Brockton, MA 02401
(617) 587-2121

VNA of Boston
100 Boylston Street
Boston, MA 02116
(617) 426-5555 x210

Concilio Hispano
105 Windsor Street
Cambridge, MA 02139
(617) 661-9406

Gardner VNA
98 Mechanic Street
Gardner, MA 01440
(617) 632-1230

VNA Home Care
451 Andover Street
North Andover, MA 01845
(617) 686-1010

OUTREACH AND TRAINING TEAMS

Anne Sullivan Center
Tewksbury Hospital
Tewksbury, MA 01876
(617) 851-6814(617) 828-4770

East Mountain Center
91 East Mountain Road
Westfield, MA 01085
(413) 737-6792

ENABLE
Community Resource Center
3 Randolph Street
Canton, MA 02021

PRESCHOOL HEALTH PROGRAM

Preschool Enrichment Team
276 High Street
Holyoke, MA 01040
(413) 536-3900

COMMUNITY LEAD POISONING PREVENTION PROGRAMS

Boston Lead Poisoning Prevention Program
Office of Environmental Affairs
Boston Health and Hospitals
818 Harrison Avenue
Boston, MA 02118
(617) 424-5965
(Serves Boston)

Merrimack Valley Lead Poisoning Prevention Program
G.L.C.A.C.
350 Essex Street
Lawrence, MA 01840
(617) 686-4470
(Serves Lawrence, Lowell and surrounding towns)

North Shore Children's Hospital
57 Highland Avenue
Salem, MA 01970
(617) 741-1679 or 741-1567
(Serves Lynn, Salem, Peabody and surrounding towns)

Southeastern Massachusetts Lead Poisoning Program
4 Park Place, Room 19
New Bedford, MA 02742
(617) 999-9930
(Serves Taunton, Brockton, New Bedford, Fall River

Springfield Visting Nurse Assoc.
600 Berkshire Avenue
Springfield, MA 01109
(413) 781-5070
Springfield Health Department
1414 State Street
Springfield, MA 01109
(413) 787-6740
(Serve Springfield)

Worcester Lead Poisoning Prevention Program
Worcester Dept. of Public Health
37 Lee Street
Worcester, MA 01602
(617) 799-8589
(Serves Worcester)

RAPE CRISIS CENTERS

NORTHEAST REGION

URSA
Project RAP
202 Rantoul Street
Beverly, MA 01915
1-800-922-URSA Hotline
(617) 927-4506 Business

Rape Crisis Services of Greater Lowell
Lowell General Hospital
295 Varnum Avenue
Lowell, MA 01854
(617) 458-2084 Hotline
452-7721 Business

Women's Resource Center
454 No. Canal Street
Lawrence, MA 01840
(617) 685-2480

SOUTHEAST REGION

Plymouth County Rape Crisis Center
646 Center Street
Brockton, MA 02401
(617) 588-8255 Hotline
588-0141 Business

New Hope
P.O. Box 48
Attleboro, MA 02703
(617) 226-4015 Business
(Taunton) 824-4757 Hotline
(Attleboro) 695-2113 Hotline

Rape Crisis Program
New Bedford Women's Center
83 Spring Street
New Bedford, MA 02740
(617) 993-1842 Business
996-6656 Hotline

Center for Individual and Family Services
78 Pleasant Street
Hyannis, MA 02601
(617) 775-1859 Business
771-1080 Hotline

BOSTON REGION

Boston Area Rape Crisis Center
99 Bishop Allen Drive
Cambridge, MA 02139
(617) 492-8306 Business
492-7273 Hotline

CPASA Roxbury Multi-Service Center 317 Blue Hill Avenue Roxbury, MA 02121	(617) 536-6500 Hotline 266-8800 Business
West Suburban YWCA 251 W. Central Street Natick, MA 01760	(617) 872-6161 Hotline 653-4464 Business

CENTRAL REGION

Rape Crisis Program, Worcester 1016 Main Street Worcester, MA 01603	(617) 791-9546 Business 799-5700 Hotline
LUK, Inc. 99 Day Street Fitchburg, MA 01420	(617) 345-0685 Business 345-7353 Hotline

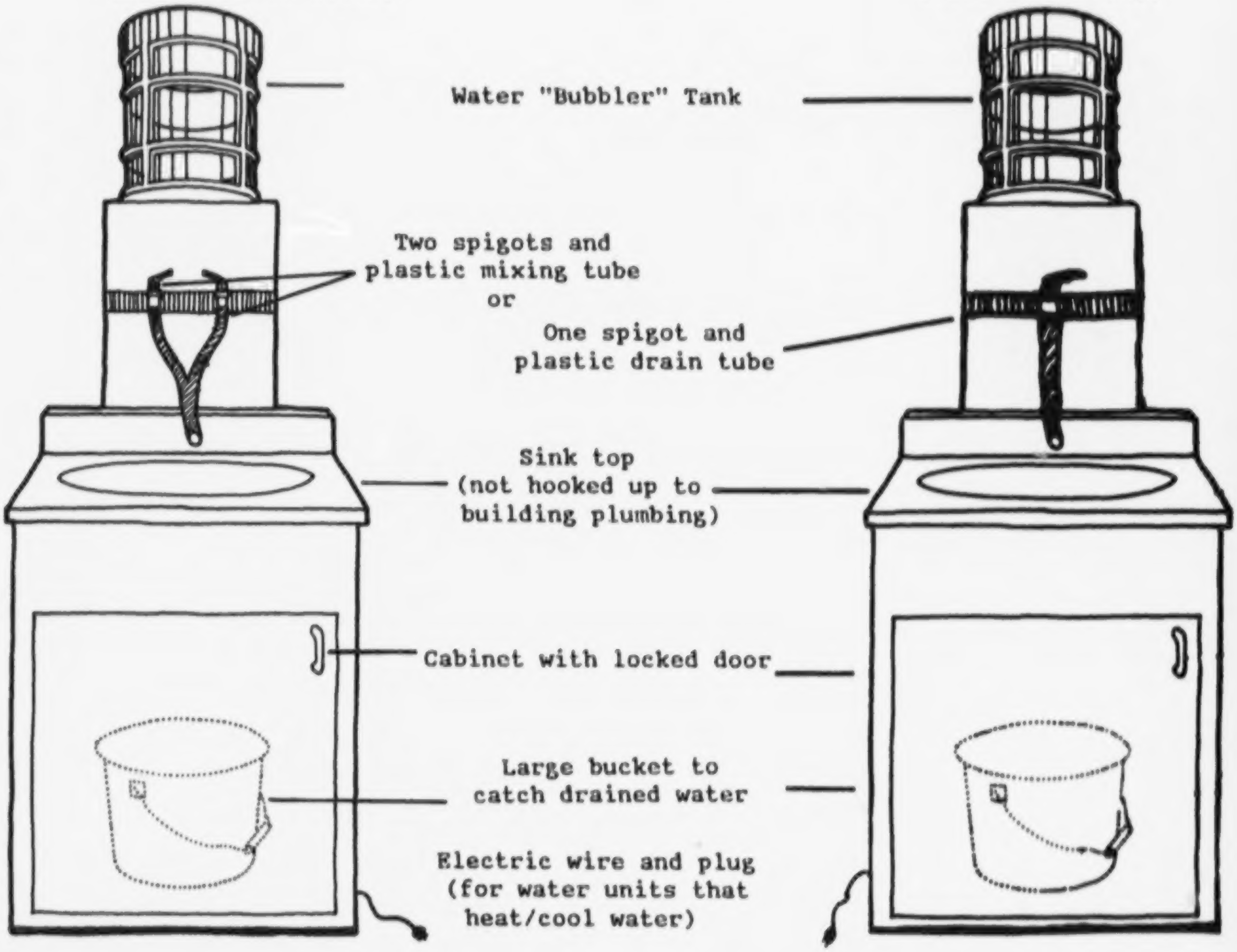
WESTERN REGION

Everywoman's Center Wilder Hall Univ. of Massachusetts Amherst, MA 01003	(413) 545-0800 Hotline 545-0883 Business
ARCH P.O. Box 80632 Springfield, MA 01138	(413) 733-1588 Business 733-7100 Hotline
NELCWIT 219 Silver Street Greenfield, MA 01301	(413) 772-0871 Business 772-0806 Hotline
Rape Crisis Center of Berkshire County 24 Charles Street Pittsfield, MA 01240	(413) 443-0089 Hotline 442-6708 Business

Appendix 4

Alternative to a Sink

To create a place for handwashing, even if plumbing is not available, use a portable water ("bubbler") tank, a sink top, and a cabinet that can be locked. Empty the drain bucket into the toilet as needed, wash and disinfect the bucket.



OPTION 1
(hot and cold water)

OPTION 2
(cold water only)

Water "Bubbler" Tank
Two spigots and plastic mixing tube
or
One spigot and plastic drain tube
Sink top (not hooked up to building plumbing)
Cabinet with locked door
Large bucket to catch drained water
Electric wire and plug (for water units that heat/cool water)

Caution: If your water bubbler has both hot and cold spigots, you MUST use plastic tubing to mix the water before it reaches the sink. Hot water can cause severe scald burns.

NOTE: If your water "bubbler" unit has only cold water, keep it unplugged so the water will remain at room temperature.

This alternative does not meet OFC regulation 7.11 (7) which requires a washbasin for every 20 children in the bathroom.

Appendix 5

Site Safety Checklist

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
GENERAL ENVIRONMENT [redacted] Floors are smooth and have a non-skid surface.				
Pipes and radiators are inaccessible to children or are covered to prevent contact.				
Hot tap water temperature for handwashing is 110°-115° F or less.				
Electrical cords are out of children's reach and are kept out of doorways and traffic paths.				
Unused electrical outlets are covered by furniture or shock stops.				
Medicines, cleansers, and aerosols are kept in a locked place where children are unable to see and reach them.				
All windows have screens that stay in place when pushed; expandable screens are not used.				
Windows can be opened 6" or less from the bottom.				
Drawers are kept closed to prevent tripping or bumps.				

Appendix 5 (cont.)

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Trash is covered at all times.				
Walls and ceilings are free of peeling paint, and cracked or falling plaster; center has been inspected for lead paint.				
There are no disease-bearing animals, such as turtles, parrots, or cats.				
Children are always supervised.				
There is no friable (crumbly) asbestos releasing in the air.				
EQUIPMENT AND TOYS Toys and play equipment are checked often for sharp edges, small parts, and sharp points.				
All toys are painted with lead-free paint.				
Toys are put away when not in use.				
Toy chests have lightweight lids or no lids.				

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Art materials are non-toxic, and have either the AP or CP label.				
Art materials are stored in their original containers in a locked place.				
Teaching aids (e.g., projectors) are put away when not in use.				
Curtains, pillows, blankets, and cloth toys are made of flame-resistant material.				
HALLWAYS AND STAIRS Stairs and stairways are free of boxes, toys, and other clutter.				
Stairways are well-lit.				
The right-hand railing on the stairs is at child height and does not wobble when held; there is a railing or wall on both sides of stairways.				
Stairway gates are in place when appropriate.				

Appendix 5 (cont.)

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Closed doorways to unsupervised or unsafe areas are always locked unless this prevents emergency evacuation.				
Staff are able to watch for strangers entering the building.				
KITCHEN Trash is kept away from areas where food is prepared or stored.				
Trash is stored away from the furnace and hot water heater.				
Pest strips are NOT used; pesticides for crawling insects are applied by a certified pest control operator.				
Cleansers and other poisonous products are stored in their original containers away from food and out of children's reach.				
Non-perishable food is stored in labelled, insect-resistant containers such as metal or plastic. Perishable food is stored in covered containers in the refrigerator.				

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Food preparation surfaces are clean and free of cracks and chips.				
Eating utensils are free of cracks and chips.				
Electrical cords are placed where people will not trip over them or pull them.				
There are no sharp or hazardous cooking utensils within children's reach (e.g., knives, glass).				
Pot handles are always turned in toward the back of the stove during cooking.				
The fire extinquisher can be reached easily in an emergency.				
All staff know how to use the fire extinquisher correctly.				
BATHROOMS Stable step stools are available when needed.				
Electrical outlets are covered with shock stops or outlet covers.				

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Cleaning products, soap, and disinfectant are stored in a locked place, out of children's reach.				
Floors are smooth and have a non-skid surface.				
The trash container is emptied daily and kept clean.				
Hot water for handwashing is 110°-115° F.				
EMERGENCY PREPARATION All staff understand their roles and responsibilities in case of emergency.				
At least one staff person is always present who is certified in first aid and CPR for infants and children.				
The first aid kit is checked regularly for supplies and is kept where it can be reached easily by staff in an emergency.				
Smoke detectors and other alarms are checked regularly to make sure they are working.				

ITEM	YES	NO	CORRECTIONS/COMMENTS	DATE MADE CORRECTION
Each room and hallway has a fire escape route posted in clear view.				
Emergency procedures and telephone numbers are posted near each phone in clear view.				
Children's emergency phone numbers are kept near the phone, where they can be reached quickly.				
All exits are clearly marked and are free of clutter.				
Doors open in the direction of exit travel.				
Cots are placed so that walkways are clear for evacuation in an emergency.				

Source: Statewide Comprehensive Injury Prevention Program (SCIPP), Department of Public Health, 150 Tremont St., Boston, MA 02111. (617) 727-1246.

Appendix 6
Playground Safety Checklist

Name and address of playground:

Name: ____________________

Street: ____________________

Town/State: ____________________

Date of this safety check: __________

Name(s) of person(s) conducting check: ____________________

____

Date of last safety check (if applicable): __________

Type and amount of equipment at playground:
How many? (Write "0" if equipment not at this playground.)

#

☐SWINGS (SEATS)
☐SLIDES
☐SEESAWS
☐CLIMBING EQUIPMENT
☐ROCKING EQUIPMENT
☐TABLES

☐SANDBOXES
☐BENCHES
☐Other: __________(specify)
__________(specify)
__________(specify)
__________(specify)

What is the surface of the playground? (Check all that apply.)

☐Asphalt
☐Bare ground (dirt)
☐Concrete
☐Grass
☐Pea gravel (smooth)
☐Rock gravel (rough)
☐Rubber mats (how thick?______)

☐Sand
☐Shredded rubber
☐Vinyl mats (how thick? ______)
☐Wood chips
☐Other__________
☐"Specialty" commercial playground surfacing - Brand:__________

Injuries to children may occur from many types of playground equipment and environmental conditions. The checklist on the following pages will help you to assess and correct hazards that may be present on your playground. While this list does not include every possible hazard that may exist at your playground site, the Playground Safety Checklist can be a helpful tool in evaluating the play environment of the children in your school or community.

Check the column marked "YES" or "NO" for each question. In most cases, a "YES" response denotes a safe condition; items requiring a "NO" response are marked by an asterisk (*) in the "NO" column. If the question does not apply to your playground, write "NA" in the "COMMENTS" column. The "COMMENTS" column should also be used for a specific description of any hazardous condition found while conducting a playground safety check.

STATEWIDE COMPREHENSIVE INJURY PREVENTION PROGRAM
Massachusetts Department of Public Health
150 Tremont Street, Boston, MA 02111

ITEM	YES	NO	COMMENTS	DATE CORRECTED
ALL EQUIPMENT Are all nuts, bolts or screws recessed, covered, or sanded down?				
Are nuts and bolts tight?				
Is wooden equipment free from splinters or rough surfaces? Is metal equipment free from rust or chipping paint?				
Is all equipment free from sharp edges?				
Has any part of the equipment corroded or frayed?		*		
Are anchors for equipment stable and buried below ground level?				
Has equipment shifted or become bent with use?		*		
Are there "V" angles on any part of the equipment (likely to cause limbs or clothing to be trapped)?		*		
Are there any open holes in the equipment forming finger traps (e.g., at the ends of the tubes)?		*		
Are any parts of the equipment missing?		*		

ITEM	YES	NO	COMMENTS	DATE CORRECTED
ALL EQUIPMENT (continued) Is equipment dry before children are allowed to play on it?				
Are the children who use the equipment of the age/developmental level for which the equipment was designed?				
GROUND SURFACE Does all elevated play equipment (slides, swings, bridges, seesaws, climbing apparatus, etc.) have 8"-12" of impact-absorbing material underneath, such as sand, pea gravel or wood chips? (Note: Pea gravel should be avoided in infant/toddler area.)				
Are surfaces raked weekly to prevent them from becoming packed down and to find hidden hazards (e.g., litter, sharp objects, animal feces, etc.)?				
Are there pools of water on the surface? (Indicates poor drainage.)		*		
Does asphalt or concrete come into contact with metal equipment where it is anchored to the ground? (Could cause corrosion.)		*		
SWINGS Are all swing seats made of canvas or other pliable material?				

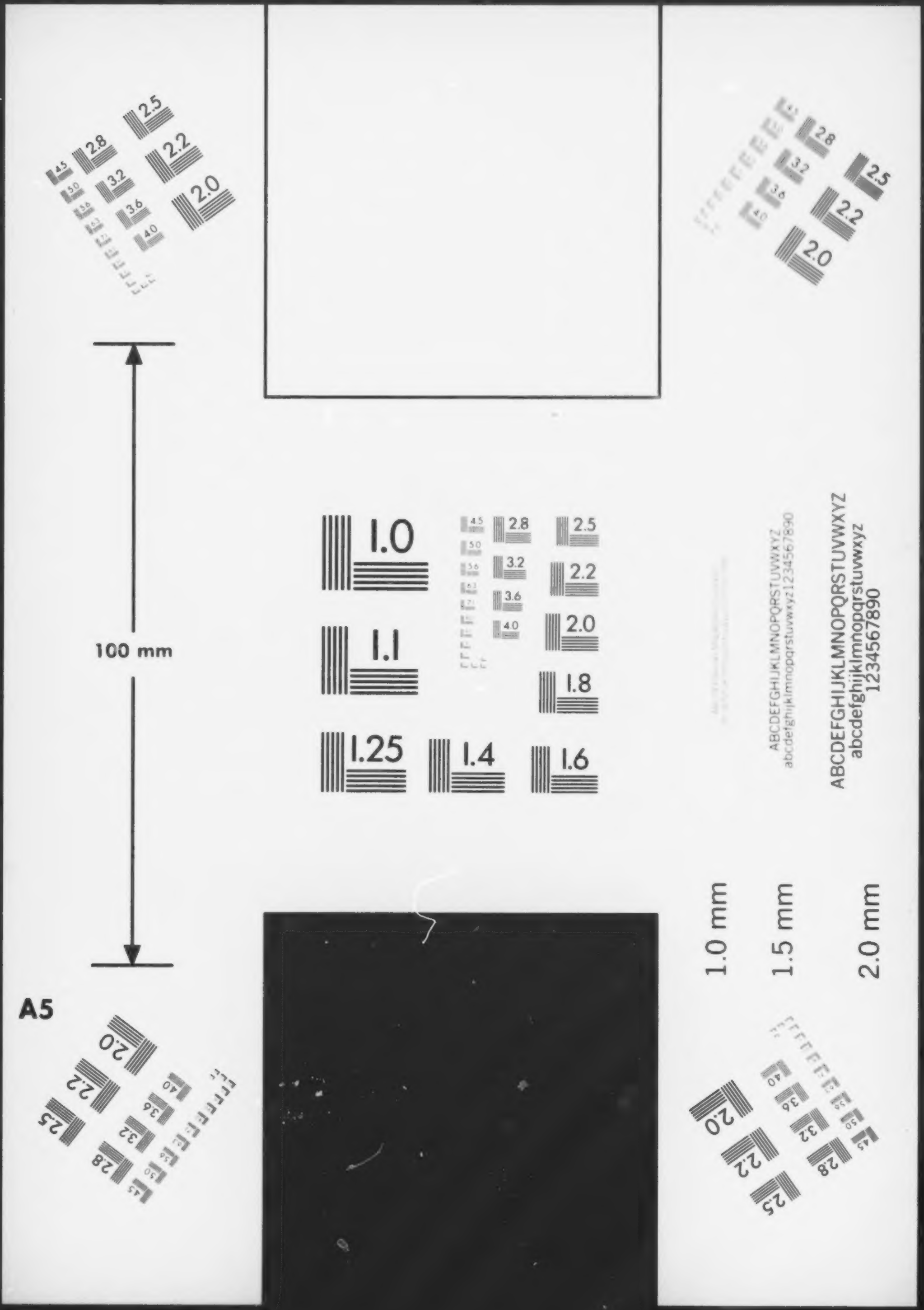
Appendix 6 (cont.)

ITEM	YES	NO	COMMENTS	DATE CORRECTED
SWINGS (continued) Are swings with back supports available for toddlers and children with disabilities?				
Have "S" or open-ended hooks been removed?				
Is the point at which the seat and chain meet designed to prevent clothing or limb entrapment?				
Are hanging rings less than 4 1/2" or more than 10" in diameter (to prevent head entrapment)?				
Are there more than two swings on any one apparatus?		*		
CLIMBING EQUIPMENT Is the height of the equipment suited to the ages and sizes of the users?				
Do handholds stay in place when grasped?				
Are rungs painted in bright or contrasting colors so children will see them?				
Do climbers have regularly-spaced footholds (7"-10" apart) from top to bottom?				

ITEM	YES	NO	COMMENTS	DATE CORRECTED
CLIMBING EQUIPMENT (continued) Are rungs, climbing bars and handrails between 3/4" and 1 1/2" in diameter to accommodate a child's hand grasp?				
Is there an easy, safe "way out" for children when they reach the top?				
Is there a 38" safety barrier (24" for 1-to-3-year olds; 32" for 3-to-6-year olds) around all sides of equipment that is more than 30" above the ground? (Space between slats should not exceed 4".)				
Are all structures less than 6 feet high?				
Is there an impact-absorbing surface under each climbing structure and 6 feet beyond all sides of the structure?				
SEESAWS Is the fulcrum enclosed or designed to prevent pinching?				
Do handholds stay in place when grasped, without turning or wobbling?				
Are wooden blocks or part of a rubber tire placed below the seat to prevent feet from getting caught?				

ITEM	YES	NO	COMMENTS	DATE CORRECTED
SLIDES Are side rims at least 2 1/2 inches high (5" for circular or "wave" slides)?				
Do slides have a platform at the top (with safety barriers) for children to rest and get into position for sliding?				
Is sliding surface faced away from the sun (north or east) OR located in the shade?				
If the slide is made in several pieces, are there any gaps in the sliding surface? (Rough edges could catch on clothing and skin or retain a sharp object.)		*		
Is the bottom of the slide less than the maximum recommended height of 16" above the ground?				
Do slide ladders or steps have handrails on both sides?				
Are the steps or rungs slip-resistant?				
Is there a flat surface at the bottom of slide for slowing down? (For slides over 4 feet high, this surface should be at least 16" in length.)				
Are wooden slides waxed, or oiled with linseed oil?				

ITEM	YES	NO	COMMENTS	DATE CORRECTED
SLIDES (continued) Is the angle of the sliding surface equal to or less than 30°?				
Are steps and rungs 7"-10" apart to accommodate children's leg and arm reach?				
Is there an impact-absorbing surface under and around the slide, and 5 feet beyond the end of the slide?				
SANDBOXES Are sandboxes located in a shaded spot?				
Is the frame sanded and smooth, without splinters or rough surfaces?				
Is sand raked every week to check for debris and to expose it to sun and air?				
Is the box covered at night to protect from moisture and animal excrement?				
Does the sandbox have proper drainage?				
ROCKING EQUIPMENT Are seating surfaces less than 39 inches from the ground?				



1.0
1.1
1.25
1.4
1.6
1.8
2.0
2.2
2.5
2.8
3.2
3.6
4.0
4.5
5.0
5.6
6.3
7.1

100 mm

A5

ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz1234567890

ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890

1.0 mm

1.5 mm

2.0 mm

ITEM	YES	NO	COMMENTS	DATE CORRECTED
ROCKING EQUIPMENT (continued) Are there any accessible parts that could cause a pinching or crushing injury?		*		
Can any part of the child's body pass beneath the equipment while it is in action? (Could cause a crushing injury.)		*		
Are there adequate handholds, footboards, and footrests?				
SPACING Do swings have adequate clearance in both directions? (14 feet beyond the furthest extension of the swing: 8 feet of impact-absorbing surface, plus a 6 foot safety zone.)				
Are swings at least 18" from each other and 28" away from the frame?				
Do slides have a 2 1/2 to 3 yard run-off space?				
Are boundaries between pieces of equipment (painted lines, low bushes, etc.) visible to children?				
Are play areas for active play (e.g., bike riding, running games) located away from areas for quiet activities (e.g., sandbox, picnic table, etc.)?				

ITEM	YES	NO	COMMENTS	DATE CORRECTED
GENERAL ENVIRONMENT Can the playground be reached safely by children?				
Is the playground accessible to people with disabilities?				
If needed, is a suitable perimeter fence provided (e.g., near road, pool, pond, etc.)?				
If seating is provided (benches, picnic tables), is it in good condition?				
Are there signs posted giving information about: - where to seek help in case of an emergency?				
- restrictions on use of playground (hours, pets)?				
- name and address of playground operator (to report hazards)?				
Are trash receptacles provided (and kept away from play area)?				
Are poisonous plants and berries removed from play area?				
Is there a source of clean drinking water available in the play area?				

ITEM	YES	NO	COMMENTS	DATE CORRECTED
GENERAL ENVIRONMENT (continued) Is there shade?				
Can the entire play area be viewed easily for proper supervision?				

Do you see any other hazards on this playground
(equipment or environmental) that are not mentioned elsewhere on this checklist?
If yes, please specify:

For additional information about playground safety, contact SCIPP and/or the Consumer Product Safety Commission at the addresses below:

STATEWIDE COMPREHENSIVE INJURY PREVENTION PROGRAM (SCIPP)
Massachusetts Department of Public Health
150 Tremont Street, 3rd Floor
Boston, MA 02111
(617) 727-1246

CONSUMER PRODUCT SAFETY COMMISSION (CPSC)
Washington, DC 20207
(800) 638-CPSC

Appendix 7

Health Team Members

An *Audiologist* conducts screening and diagnosis of hearing problems and may recommend a hearing aid or suggest training approaches for people with hearing handicaps.

A *Dentist* conducts screening, diagnosis, and treatment of the teeth and gums.

A *Neurologist* is a medical doctor who conducts screening, diagnosis, and treatment of brain and nervous system disorders.

A *Nutritionist* evaluates a person's food habits and nutritional status. This specialist can provide advice about normal and therapeutic nutrition, and information about special feeding equipment and techniques to increase a person's self-feeding skills.

An *Occupational Therapist* evaluates and treats children who may have difficulty performing self-help, play, or preschool-related activities. The aim is to promote self-sufficiency and independence in these areas.

An *Opthamologist* is a medical doctor who conducts screening, diagnosis, and treatment of diseases, injuries, or birth defects that limit vision.

An *Optician* assembles corrective lenses and frames. He or she will advise in the selection of frames and fit the lenses prescribed by the optometrist or opthalmologist to the frames. An optician also fits contact lenses.

An *Optometrist* examines the eyes and related structures to determine the presence of visual problems, eye diseases, or other problems.

An *Orthopedist* is a medical doctor who conducts screening, diagnosis, and treatment of diseases and injuries to muscles, joints, and bones.

An *Otolaryngologist* is a medical doctor who conducts screening, diagnosis, and treatment of ear, nose, and throat disorders. This specialist may also be known as an E.N.T. (ear, nose, and throat doctor).

An *Otologist* is a medical doctor who conducts screening, diagnosis, and treatment of ear disorders.

A *Pediatrician* is a medical doctor who specializes in childhood diseases and problems, and in the health care of children.

A *Physical Therapist* evaluates and plans physical therapy programs. He or she directs activities for promoting self-sufficiency primarily related to gross motor skills such as walking, sitting, and shifting position. He or she also helps people with special equipment used for moving, such as wheelchairs, braces, and crutches.

A *Psychiatrist* is a medical doctor who conducts screening, diagnosis, and treatment of psychological, emotional, behavioral, and developmental or organic problems. Psychiatrists can prescribe medication. They generally do not administer tests. There are different kinds of psychiatrists.

A *Psychologist* conducts screening, diagnosis, and treatment of people with social, emotional, psychological, behavioral, or developmental problems. There are many different kinds of psychologists.

A *Social Worker* provides services for individuals and families experiencing a variety of emotional or social problems. These services may include direct counseling of an individual, family, or group; advocacy; or consultation with preschool programs, schools, clinics, or social agencies.

A *Speech-Language Pathologist* conducts screening, diagnosis, and treatment of children and adults with communication disorders. This person may also be called a *speech clinician* or *speech therapist*.

Source: Mainstreaming Preschoolers Series, U. S. Department of Health and Human Services.

Appendix 8
Developmental Red Flags for Children Ages Three to Five

INTRODUCTION

In observing preschool-age children, child-care providers and parents frequently wonder if particular behaviors are something they should worry about. There is no way to make these decisions simply or with total certainty. Observation and screening tools are always limited because they summarize enormous amounts of information for a wide variety of readers. However, they can be very useful in the day care setting if used appropriately. The Preschool Enrichment Team, Inc. has developed "Red Flags" as a developmental observation tool to assist those who care for children ages three to five.

The single most useful tool in observing young children is a *thorough* knowledge of normal growth and development. *There is no substitute.* The process of development varies with each individual child, but normal development follows a predictable sequence of stages according to a biological timetable. Interruptions in the *pattern* and *sequence of stages* should put an observer on the alert.

Variations in the *timetable* of a child's development are of much less concern. Each age and stage of development is of course affected by the personality of each child and represents the skills the child has developed: motor, language, cognitive, personal-social. Children are seldom in one separate stage of development. They are continuously changing and emerging from a younger stage into an older stage, thereby combining characteristics of both.

WHAT ARE RED FLAGS?

"Red flags" are behaviors that should warn you to *Stop, Look, and Think.* Having done so, you may decide there is nothing to worry about at all, or that there is a cluster of red flag behaviors that do signal a possible problem. The following guidelines will help you use red flags more effectively.

- Behavior descriptions are sometimes repeated under different areas of development. It is difficult to categorize children's behavior. Your job is to notice and describe what you see that concerns you. Do not try to decide into which category it fits.

- Look for *patterns or clusters* of red flags. One, or a few in isolation, may not be significant.

- Observe a child in a variety of situations in order to watch for the behaviors that concern you.

- Compare the child's behavior to the "norm," which should include children who are six months younger or six months older as well as the same age.

- Note how the child has grown over the past three to six months. Be concerned if you feel the child has not progressed.
- Know normal growth and development. What may be a red flag at one age can be a perfectly normal behavior at another.
- Keep in mind that each child's development is shaded and toned by personality, temperament, family structure and dynamics, culture, experiences, physical characteristics, and the match of child to caregiver and family to child care setting.
- Use a detailed skills list to develop a skills profile for the child.

■ CONSULTATION AND REFERRAL

None of us knows all there is to know about normal growth and development. Use all of your area resources to help you think about a child, then consider the following:

- Describe in detail what you see that concerns you. Do not try to conclude what it means or to label it. It is much more helpful to parents, consultants, and to the child to have descriptions, not conclusions.
- Talk with the child's parent(s).
- Waiting and watching for a while is a reasonable decision *if* you have observed growth in the past three to six months. If no growth in the area of concern can be described, then it is time to ask for help.
- Know that you if recommend further evaluation of a problem and your concerns are confirmed, you have helped a child and family begin to solve a problem.
- Also, be glad if further evaluation does not indicate that there is a problem at this time.

NOTE: The following categories of red flags are intended to guide your observations of preschool children ages three to five. They are not applicable to infants or children under three.

Appendix 8 (cont.)

SOCIAL EMOTIONAL DEVELOPMENT

This area of development includes:

- Relationships
- Separations
- Involvement
- Focusing
- Affect
- Self-Image
- Anxiety Level
- Impulse Control
- Transitions
- Fantasy vs. Reality

RED FLAGS

Be alert to a child who, compared with other children his age or six months older or younger:

1. Does not seem to recognize self as a separate person, or does not refer to self as "I".

2. Does not separate from parent or separates too easily.

3. Is anxious, tense, restless, compulsive, cannot get dirty or messy, has many fears, engages in excessive self-stimulation.

4. Seems preoccupied with his inner world; conversations do not make sense.

5. Shows little or no impulse to control; hits or bites as first response; cannot follow a classroom routine.

6. Expresses emotions inappropriately; laughs when sad, denies feelings; facial expressions do not match emotions.

7. Cannot focus on activities; short attention span; cannot complete anything; flits from toy to toy.

8. Relates only to adults, cannot share adult attention, consistently sets up power struggle, or is physically abusive to adults.

9. Consistently withdraws from people, prefers to be alone; no depth to relationships; does not seek or accept affection or touching.

10. Treats people as objects; has no empathy for other children; cannot play on another child's terms.

11. Is consistently aggressive, frequently hurts others deliberately; shows no remorse or is deceitful in hurting others.

HOW TO SCREEN

1. Observe child:

   - Note overall behavior--what does the child do all day, with whom, with what does s/he play.
   - Note when, where, how frequently and with whom problem behaviors occur.
   - Describe behavior through clear observations. Do not diagnose.

2. Note family history:

   - Make up of family, who cares for child.
   - Has there been a recent move, death, new sibling, or long or traumatic separations?
   - What support does family have -- extended family, friends?

3. Note developmental history and child's temperament since infancy, e.g.:

   - activity level
   - regularity of child's routine--sleeping, eating
   - distractibility
   - intensity of child's responses
   - persistence/attention span
   - positive or negative mood
   - adaptability to changes in routine
   - level of sensitivity to noise, light, touch, etc.

COMMUNITY RESOURCES

- Child's health care provider
- Local mental health center (may have a preschool person or outreach team)
- Local family service organization
- Local child guidance center
- Local Help for Children or Council for Children (to help locate a resource)
- Preschool Enrichment Team (in Holyoke-Springfield area)
- Local school system, Early Childhood Special Needs Coordinator
- Birth to Six Resource Directory, Regional Offices, Department of Education
- DPH Early Intervention Program
- Integrated Preschool Programs and Outreach and Training Teams
- Regional Office of Department of Public Health
- Local libraries

MOTOR DEVELOPMENT -- FINE MOTOR, GROSS MOTOR, PERCEPTUAL

This area of development includes:

- Quality of movement
- Level of development
- Sensory integration

RED FLAGS

Pay extra attention to:

1. The child who is particularly uncoordinated. For example:
   - has lots of "accidents"
   - trips, bumps into things
   - awkward getting down/up, climbing, jumping, getting around toys and people
   - stands out from the group in structured motor tasks -- such as walking, climbing stairs, jumping, standing on one foot
   - avoids the more physical games
2. The child who relies heavily on watching his/her own or other peoples' movements in order to do them himself or herself. For example:
   - may have to watch his/her feet on the stairs
   - may visually study another child's movements in circle games
   - may frequently misjudge distances
   - may become particularly uncoordinated or off-balance with eyes closed
3. The child who, compared to peers, uses much more of his/her body to do the task than the task requires. For example:
   - dives onto the ball (as though to cover the fact that s/he cannot coordinate a response)
   - uses tongue, feet, or other body parts to "help" in coloring, cutting, tracing, or with other concentration
   - extremely heavy coloring
   - leaning over the table when concentrating on a fine motor project
   - in doing wheelbarrow, the knees and feet keep pulling under the body or rump is up in the air
4. The child with extraneous and involuntary movements. For example:
   - while painting with one hand, the other hand is held in the air or waving
   - chronic toe walking
   - twirling or rocking movements
   - hand shaking or finger tapping

5. The child who involuntarily finds touching uncomfortable. For example:

   - flinches or tenses when touched or hugged
   - avoids cramped situations in a circle, at a table, in line
   - avoids activities which require touching or close contact
   - may be uncomfortable lying down, particularly on his/her back
   - reacts as if "attacked" when unexpectedly bumped
   - blinks, protects self from a ball even when trying to catch it

6. The child who compulsively craves being touched or hugged. Or, the older child who almost involuntarily has to feel things to understand them. For example:

   - clings to, or lightly brushes, the teacher a lot
   - always sits close to or touches kids in a circle
   - strongly attracted to sensory experiences -- such as with blankets, soft toys, water, dirt, sand, paste, hands in food

7. The child who has had a reasonable amount of experience with fine motor tools but whose skill does not improve proportionately. For example:

   - older child who still can only snip with scissors or whose cutting is extremely choppy
   - extremely heavy crayon pressure
   - older child who still cannot color within the lines on a simple project
   - frequent switching of hands with crayon, scissors, paint brush in the older child
   - experienced child who tries but cannot help getting paste, paint, sand, water "everywhere"
   - the child who is very awkward with, or chronically avoids, small manipulative materials

8. The child who is especially poor at new but simple puzzles, at coloring, structured art projects, and drawing a person without practice. For example:

   - even when trying hard, takes much longer to do the task and the final result is still poor compared to peers
   - shows lots of trial/error behavior when trying to do a puzzle
   - mixes up top/bottom, left/right, front/back, etc., on simple projects where a model is to be copied
   - the older child who uses blocks or small cubes to repeatedly build and crash tower structures and who seems fascinated and genuinely delighted with the novelty of the crash
   - the older child who still does a lot of scribbling

■ **HOW TO SCREEN**

Note level and quality of development as compared with other children in the group.

COMMUNITY RESOURCES

- Child's health care provider
- Registered Physical Therapist (RPT), Registered Occupational Therapist (OTR), preferably with pediatric experience
- Local school system/Early Childhood Special Needs Coordinator
- Private rehabilitation center
- Regional office of Department of Public Health
- Local hospital/physical or occupational therapy department
- American Physical Therapy Assn., local chapter
- American Occupational Therapy Assn., local chapter

SPEECH AND LANGUAGE DEVELOPMENT

This area of development includes:

- Articulation (Pronouncing sounds)
- Dysfluency(Stuttering)
- Voice
- Language (Ability to use and understand words)

RED FLAGS

1. *Articulation. Watch for the child:*

    - Whose speech is difficult to understand, compared with peers.
    - Who mispronounces sounds.
    - Whose mouth seems abnormal, e.g., excessive under- or overbite; swallowing difficulty; poorly lined-up teeth.
    - Who has difficulty putting word sounds in proper sequence.
    - Cannot be encouraged to produce age-appropriate sound.
    - Has history of ear infections or middle ear disorders.

NOTE:

Most children develop the following sounds correctly by the ages shown: (i.e., don't worry about a three-year-old who mispronounces "t").

two yrs. old - all vowel sounds
three " " - p,b,m,w,h
four " " - t,d,n,k,h,ng
five " " - f,j,sh
six " " - ch,v,r,l
seven " " - s,z, voiceless and voiced "th"

2. *Dysfluency* (Stuttering). *Note the child who, compared with others his age:*

- Shows excessive:
  - repetitions of sounds, words (m-m-m; I-I-I-I-).
  - prolongations of sounds(mmmmmmmmmmmmmmm).
  - hesitations or long blocks during speech, usually accompanied by tension or struggle behavior.
  - putting in extra words (um,uh,well).

- Shows two or more of the following while speaking:
  - hand clenching
  - eye blinking
  - swaying of body
  - pill rolling with fingers
  - no eye contact
  - body tension or struggle
  - breathing irregularly
  - tremors
  - pitch rise
  - frustration
  - avoidance of talking

- Is labelled a stutterer by parents. Remember, stuttering is NOT considered abnormal in the preschool years.

- Is aware of his dysfluencies.

3. *Voice. Note the child whose:*

- Rate of speech is extremely fast or slow.
- Voice is breathy or hoarse.
- Voice is very loud or soft.
- Voice is very high or low.
- Voice sounds very nasal.

4. *Language.* (Ability to use and understand words) *Note the child who:*

- Does not appear to understand when others speak, even though hearing is normal.
- Is unable to follow one- or two-step directions.
- Communicates by pointing, gesturing.
- Makes no attempt to communicate with words.
- Has small vocabulary for age.
- Uses parrot-like speech (imitates what others say).
- Has difficulty putting words together in a sentence.
- Uses words inaccurately (calls a "fire" a "burn", or a "knife" a "fork".)

- Demonstrates difficulty with three or more of the following:
  - making a word plural
  - changing tenses of verb
  - using pronouns
  - using negatives
  - using possessives
  - naming common objects
  - telling function of common objects
  - using prepositions

NOTE:

- *Two-year-olds use mostly nouns, few verbs.*
- *Three-year-olds use nouns, verbs, some adverbs, adjectives, prepositons.*
- *Four-year-olds use all parts of speech.*

HOW TO SCREEN

1. Observe child: note when, where, how frequently and with whom problem occurs.
2. Check developmental history--both heredity and environment play an important part in speech development.
3. Look at motor development which is closely associated with speech.
4. Look at social-emotional status which can affect speech and language.
5. Write down a speech sample.
6. Check hearing status.
7. Note number of speech sounds or uses of language.

COMMUNITY RESOURCES

- Child's health care provider
- Local school system/Early Childhood Special Needs Coordinator
- Area college or university, Communications Disorders department
- Public or private speech clinic
- Hospitals
- Medical schools
- Head Start program
- Private speech practitioner
- Early Intervention Program
- American Speech, Language, and Hearing Assn.
- Also see Social/Emotional Resources.

HEARING

Even a mild or temporary hearing loss in a preschool- or school-age child may interfere with speech, language, or social and academic progress. If one of the behaviors listed is typical of a child, s/he may have a hearing loss. If more than one of the behaviors is observed, it is more likely that a problem exists.

RED FLAGS

1. *Speech and Language. Look for the child:*

   - Whose speech is not easily understood by people outside the family.
   - Whose grammar is poorer than other children of the same age.
   - Who does not use speech as much as other children of the same age.
   - Who has unusual voice (hoarseness, "stuffy" quality, lack of inflection, or voice which is usually too loud or too soft).

2. *Social Behavior* (at home and in school). *Look for the child who:*

   - Is shy or hesitant in answering questions or joining in conversation.
   - Misunderstands questions or directions; frequently says "huh" or "what" in response to questions.
   - Appears to ignore speech; hears "only what he wants to."
   - Is unable to tune in on speech, particularly in noisy situations.
   - Is unusually attentive to speaker's face, or unusually inattentive to speaker, turns one ear to speaker.
   - Has difficulty with listening activities such as story time; difficulty following directions.
   - Has short attention span.
   - Is distractable and restless; tends to shift quickly from one activity to another.
   - Is generally lethargic or disinterested in most day-to-day activities.
   - Is considered a "behavior problem," too active or aggressive, or too quiet and withdrawn.

3. *Medical Indications. Look for the child who:*

   - Has frequent or constant upper respiratory tract infections, congestion which appears related to allergies, or a "cold" over several weeks or months.
   - Has frequent earaches, ear infections, throat infections, or middle ear problems.
   - Has had draining ears on one or more occasions.
   - Is mouth breather and snorer.
   - Is generally lethargic; has poor color.

Appendix 8 (cont.)

HOW TO SCREEN

1. Conduct pure tone audiometry and acoustic reflex for hearing, age three and older.
2. Conduct tympanometry for middle ear function, all ages.
3. Note history (behavioral and medical).

COMMUNITY RESOURCES

- Child's health care provider.
- Area college or university/Communication Disorders or Audiology department.
- Hearing or speech and hearing clinic.
- Local school system.
- Audiologist
- Ear, nose,throat specialist (otorhinolaryngologist)
- DPH High Risk for Infant Deafness Program (call regional health office)
- DPH Early Intervention Program

VISION

We are looking at:

- Skills
- Acuity (ability to see at a given distance)
- Disease

RED FLAGS

Note during class and during vision screenings:

1. Eyes
    - watery
    - discharge
    - lack of coordination in directing gaze of both eyes
    - redness
    - sensitivity to light
2. Eyelids
    - crusts on lids or among lashes
    - redness
    - recurring sties or swollen eyelids

3. Behavior and Complaints

- rubs eyes excessively
- dizziness, headaches, nausea on close work
- attempts to brush away blur
- itchy, burning, scratchy eyes
- contorts face or body when looking at distant objects, or thrusts head forward; squints or widens eyes
- blinks eyes excessively; holds book too close or too far; inattentive during visual tasks
- shuts or covers one eye; tilts head
- eyes appear to cross, or wander, especially when tired

■ HOW TO SCREEN

1. Note child's medical history. Has child had an eye exam? If not, recommend one.

2. Screen at school using a screening tool appropriate for preschoolers such as:
   a. Snellen E Chart
   b. Broken Wheel Cards

See Resources, Appendix 24.

■ COMMUNITY RESOURCES

- For screening, contact service organizations such as Women's Club, Lion's Club.
- To be trained to screen at the center, contact the Society for Prevention of Blindness, or the Department of Public Health. The center's health consultant may be able to help.
- For eye examination, refer to an opthalmologist or optometrist.

Appendix 9

Selected Early Childhood Developmental Screening Instruments

NAME OF SCREENING INSTRUMENT: Denver Developmental Screening Test (DDST)

AUTHORS: W.F. Frankenburg, J. Dodds, A. Fandal, E. Kazuk, and M. Cohrs

AGE RANGE COVERED BY TEST: 2 weeks - 6 years

DESCRIPTION: The DDST consists of 105 items from which a selection is made for a specific age range. The items are grouped in four areas: personal/social, fine motor/adaptive, language, and gross motor.

LANGUAGES AVAILABLE (in addition to English): Spanish

TOTAL COST: Manual, materials, and scoresheets - $37.00/ea; S&H - 10% of total

AVAILABLE FROM: Denver Developmental Materials, P.O. Box 20037, Denver, CO 80220-0037, 303-355-4729.

COMMENTS: The DDST is the best-known and the most widely used developmental screening instrument available. With its wide age range, a child can be screened with the same test across a period of several years. The scoresheet is constructed ingeniously and provides a great deal of normative information for the tester.

The test has been shown to be more accurate in predicting outcomes of infants and severely impaired children than in predicting the outcomes of preschoolers or mildly handicapped children. Very few children who are not at risk are incorrectly referred by the DDST. However, a majority of the children who are at risk are overlooked by this test. The low sensitivity rates indicate that although the DDST rarely overrefers children, it seriously underrefers them. Because of this problem, caution should be used when interpreting results from the DDST.

NAME OF SCREENING INSTRUMENT: Minneapolis Preschool Screening Instument (MPSI)

AUTHOR: R. Lichtenstein

AGE RANGE COVERED BY TEST: 3 years, 7 months - 5 years, 4 months

DESCRIPTION: The test consists of 50 items that are divided among 11 subtests: building, copying shapes, providing information, matching shapes, completing sentences, hopping and balancing, naming colors, counting, using prepositions, identifying body parts, and repeating sentences.

TOTAL COST: Manual, materials, and scoresheets - $35.00/ea; no S&H - extra follow-up sheet - $30.00

AVAILABLE FROM: Special School District #1, Planning & Development Department, 807 NE Broadway, Minneapolis, MN 55413, 612-627-2190.

COMMENTS: The MPSI is a well-developed test that excludes items requiring extensive examiner judgment (e.g., expressive language and most gross motor items). It includes a higher proportion of classroom readiness tasks than most developmental screeening tests.

While the MPSI has been subjected to a wide range of tests by its author to establish its validity, its predictive validity is based on comparisons with a teacher report scale that lacks well-established validity or replication. Nevetheless, the MPSI appears to be a good predictor of learning problems for at least a one-year period.

NAME OF SCREENING INSTRUMENT: The McCarthy Screening Test (MST)

AUTHOR: D. McCarthy

AGE RANGE COVERED BY TEST: 4 years - 6 1/2 years

DESCRIPTION: The MST consists of 6 of the 18 subtests of the MSCA (McCarthy Scale of Childhood Achievent): Right-Left Orientation, Verbal Memory, Draw-A-Design, Numerical Memory, Conceptual Grouping, and Leg Coordination.

TOTAL COST: Manual, materials, and scoresheets - $98.00/ea; S&H 6 1/2% of total

AVAILABLE FROM: Order Service Center, Psychological Corporation, P.O. Box 9954, San Antonio, TX 78204, 212-517-8184.

COMMENTS: The MST is a promising instrument. Because the MST is identical with six of the subtests of the MSCA (McCarthy Scale of Childhood Achievement) which has an upper age range of 8 years, it may be more discriminating for academically and developmentally more advanced children than other screening tests. However, it has been distributed prematurely. Reliability and validity data have not been independently obtained with the MSCA. Furthermore, studies of the factor structure of the MST indicate that the subtests all measure parts of the same attribute (cognitive and sensorimotor functions) in varying degrees. Because no validity data were reported on the MST during its development, and no cross validation with an independent criterion has been attempted, the MST cannot be used without some caution concerning its predictions.

NAME OF SCREENING INSTRUMENT: Early Screening Inventory (ESI)

AUTHORS: S.J. Meisels and M.S. Wiske

AGE RANGE COVERED BY TEST: 4 years - 6 years

DESCRIPTION: The ESI is composed of 30 items that are related to three general areas of development: visual-motor/adaptive functioning, language and cognition, and gross motor/body awareness.

LANGUAGES AVAILABLE (in addition to English): Spanish and Korean

TOTAL COST: Manual, materials, and scoresheets - $39.95/ea; S&H 5%

AVAILABLE FROM: Teachers College Press, c/o Harper & Row, Keystone Industrial Park, Scranton, PA 18512
800-242-7737

COMMENTS: The ESI is an easily learned, brief screening instrument that samples developmental, rather that school achievement, abilities and focuses on performance in a wide range of developmental areas. The test yields a total score that can be converted into an OK, rescreen or refer decision. Results from several reliability and validity studies demonstrate that the ESI predicts school performance with moderate to excellent accuracy through the end of second grade.

The predictive sensitivity of the ESI is somewhat higher than its specificity: it overrefers slightly more than it underrefers. Furthermore, although the test does not appear to have any inherent bias, and concurrent validity was based on a stratified sample, the long-term validity of the instrument (kindergarten to grade 4) was established with a group of low- to lower-middle SES urban, White children. Nevertheless, the ESI makes a substantial contribution to the short-term and longitudinal prediction of children at risk for learning problems or handicapping conditions.

Appendix 10

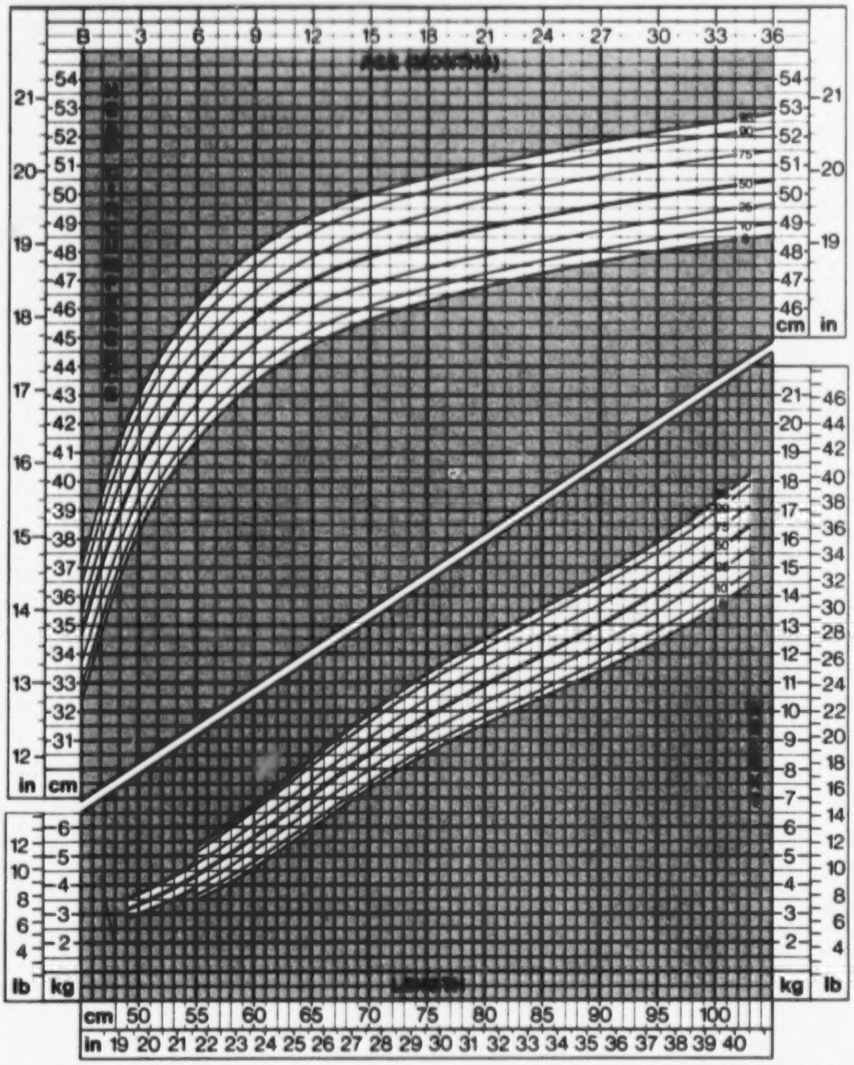
Department of Education/Regional Education Centers

REGIONAL CENTER	PHONE
Greater Boston Regional Education Center 75 Acton Street Arlington, MA 02174	(617) 727-1470
Northeast Regional Education Center 219 North Street North Rading, MA 01864	(617) 727-0600 664-5723
Southeast Regional Education Center P.O. Box 29 Middleborough, MA 02346 (at Lakeville Hospital)	(617) 727-1440, ext. 445 or 947-1231
Central Massachusetts Regional Education Center Beaman Street, Route 140 West Boylston, MA 01583	(617) 727-1346 835-6266
Greater Springfield Regional Education Center 88 Massasoit Avenue West Springfield, MA 01089	(617) 727-7166 (413) 739-7271
Northwest Regional Education Center Mark Hopkins Hall Church Street North Adams, MA 01247	(617) 727-8452 (413) 664-4511, ext. 392
Early Childhood Project Mass. Department of Education 1385 Hancock Street Quincy, MA 02169	(617) 727-7478

Appendix 11
Growth Charts

BOYS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________ RECORD # ____________



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Research Institute, Wright State University School of Medicine, Yellow Springs, Ohio.

© 1982 ROSS LABORATORIES

DATE	AGE	LENGTH	WEIGHT	HEAD CIRC	COMMENT

Better than cow milk during the first year
SIMILAC® Infant Formulas

ADVANCE®
Nutritional Beverage

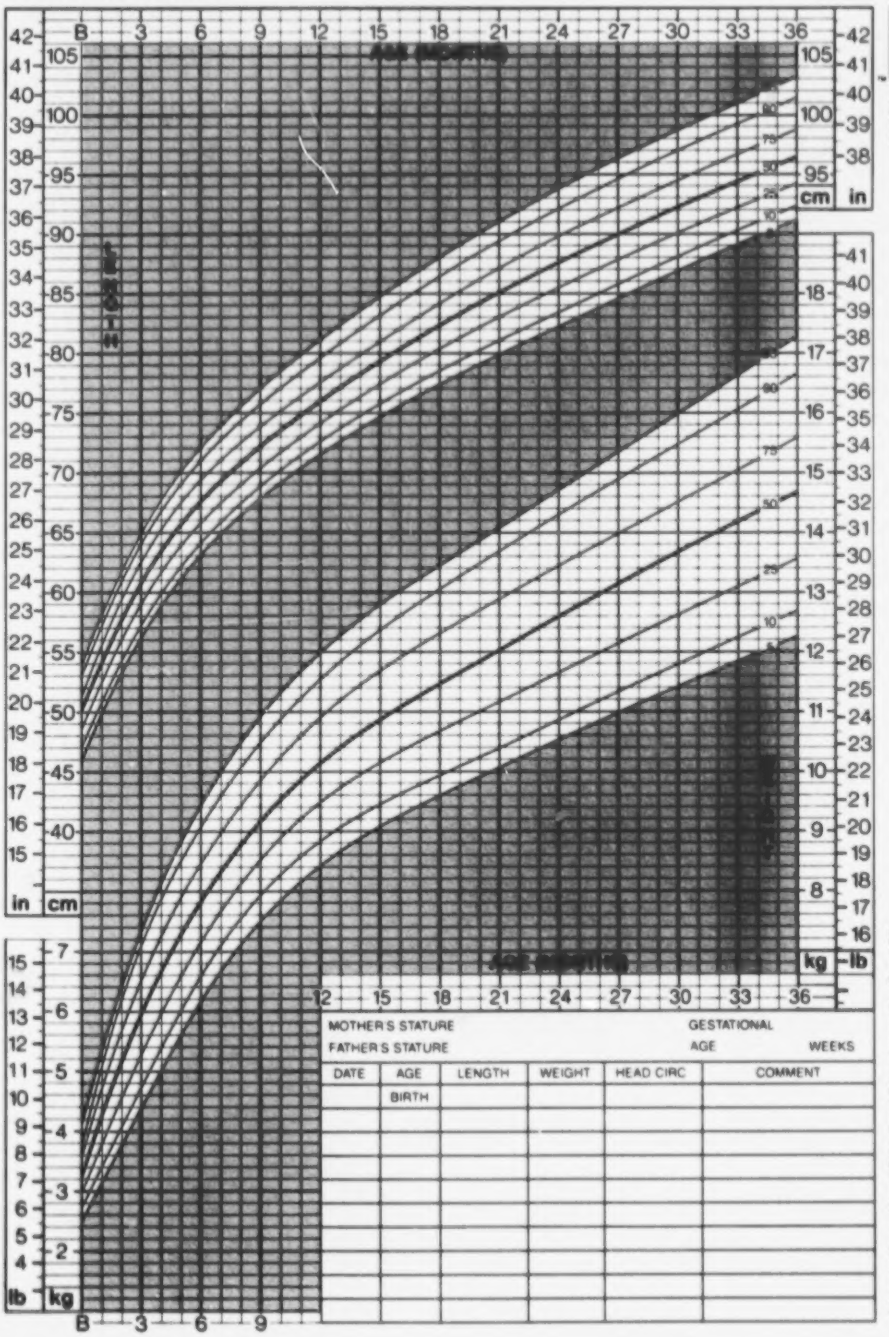
For milk sensitivity
The ISOMIL® System of Soy Protein Formulas

ROSS LABORATORIES
COLUMBUS, OHIO 43216
DIVISION OF ABBOTT LABORATORIES, USA

G105 DECEMBER 1982

BOYS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________ RECORD # ______________



MOTHER'S STATURE ______ GESTATIONAL
FATHER'S STATURE ______ AGE ______ WEEKS

DATE	AGE	LENGTH	WEIGHT	HEAD CIRC	COMMENT
	BIRTH				

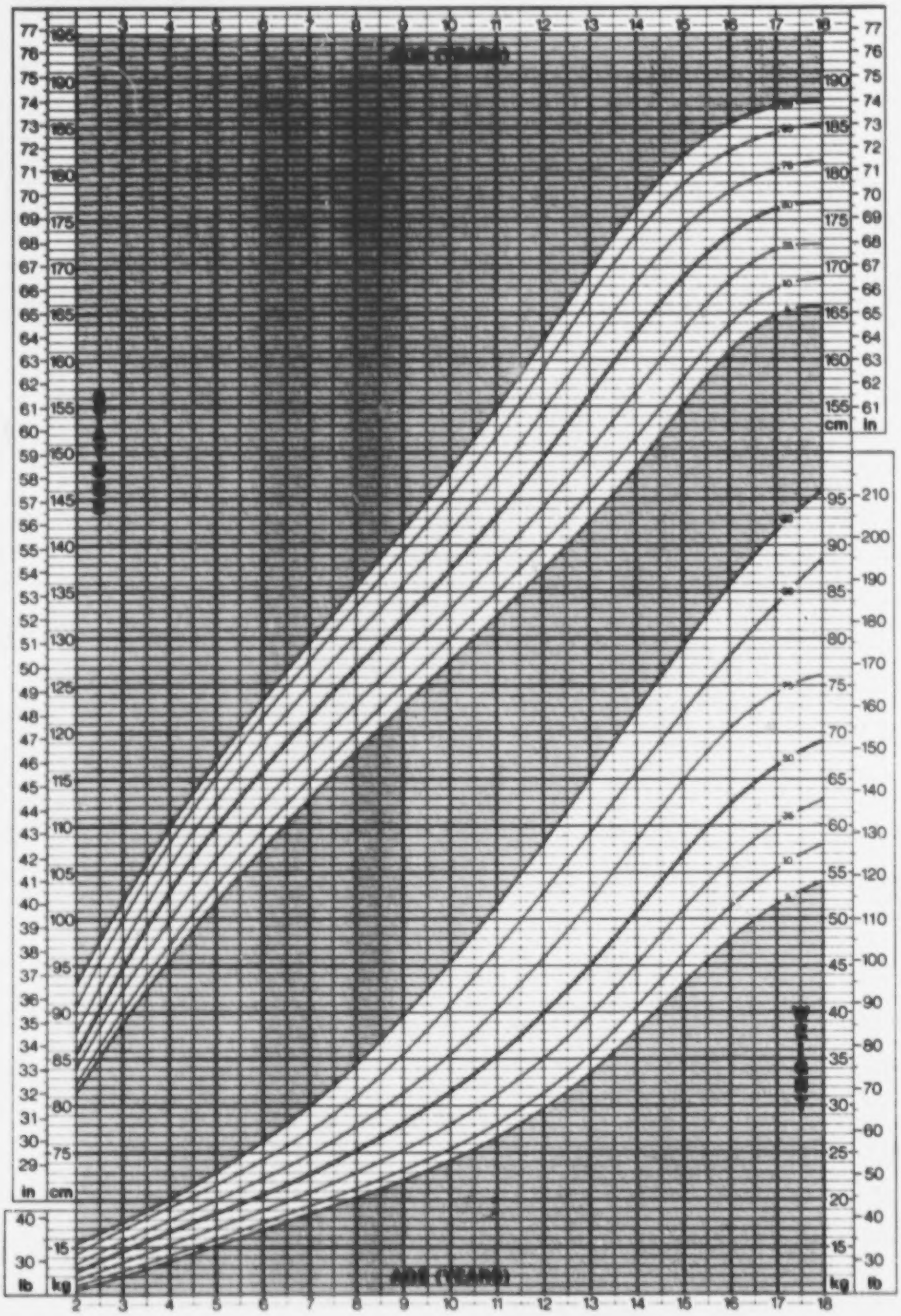
Ross Growth & Development Program

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Research Institute, Wright State University School of Medicine, Yellow Springs, Ohio.

© 1982 ROSS LABORATORIES

BOYS: 2 TO 18 YEARS PHYSICAL GROWTH NCHS PERCENTILES*

NAME ____________ RECORD # ____________



Provided as a
service of
Ross Laboratories

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.

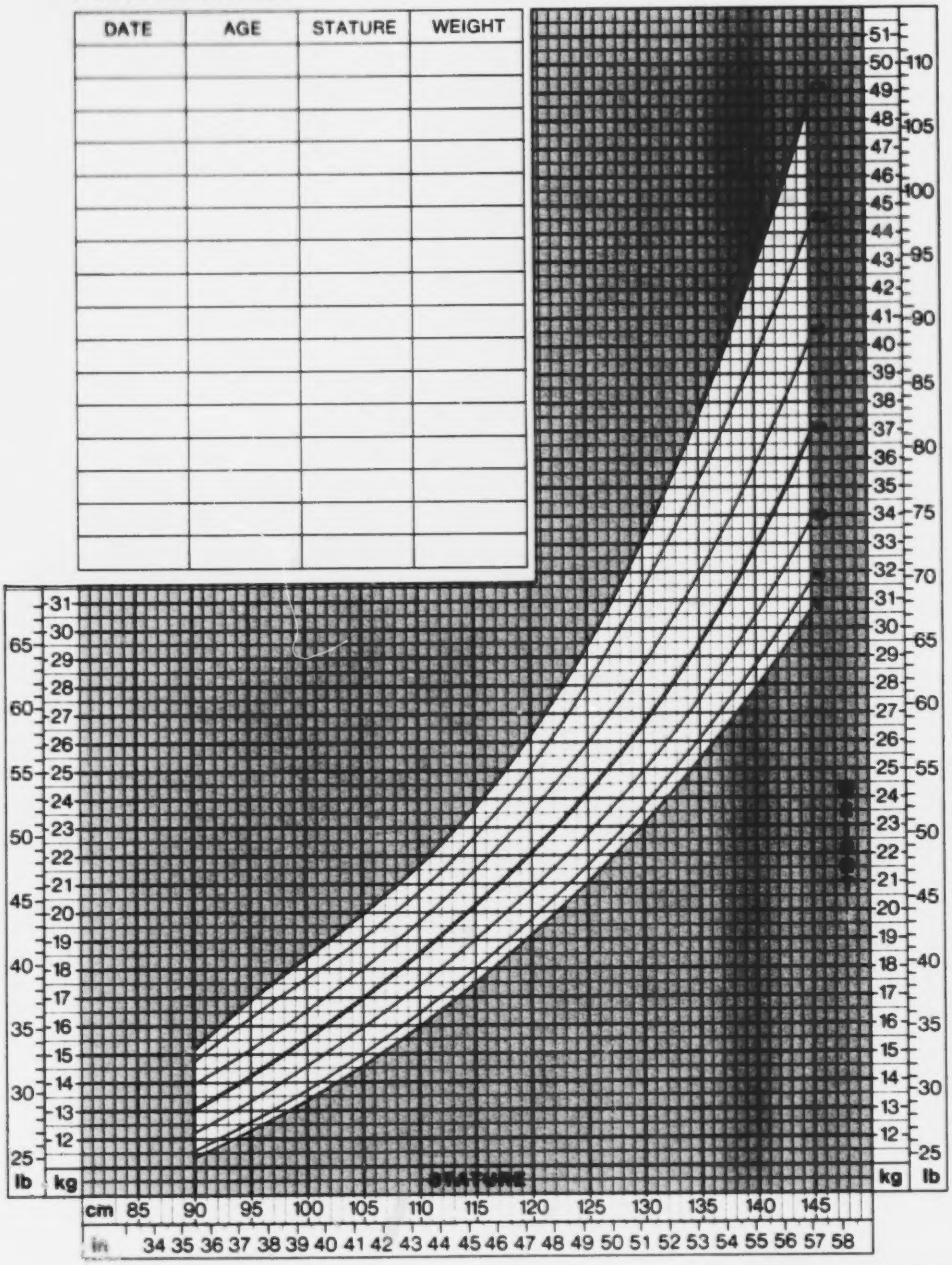
© [illegible] ROSS LABORATORIES

Appendix 11 (cont.)

BOYS: PREPUBESCENT PHYSICAL GROWTH NCHS PERCENTILES*

NAME ____________________ RECORD # ____________

DATE	AGE	STATURE	WEIGHT



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

© 1980 ROSS LABORATORIES

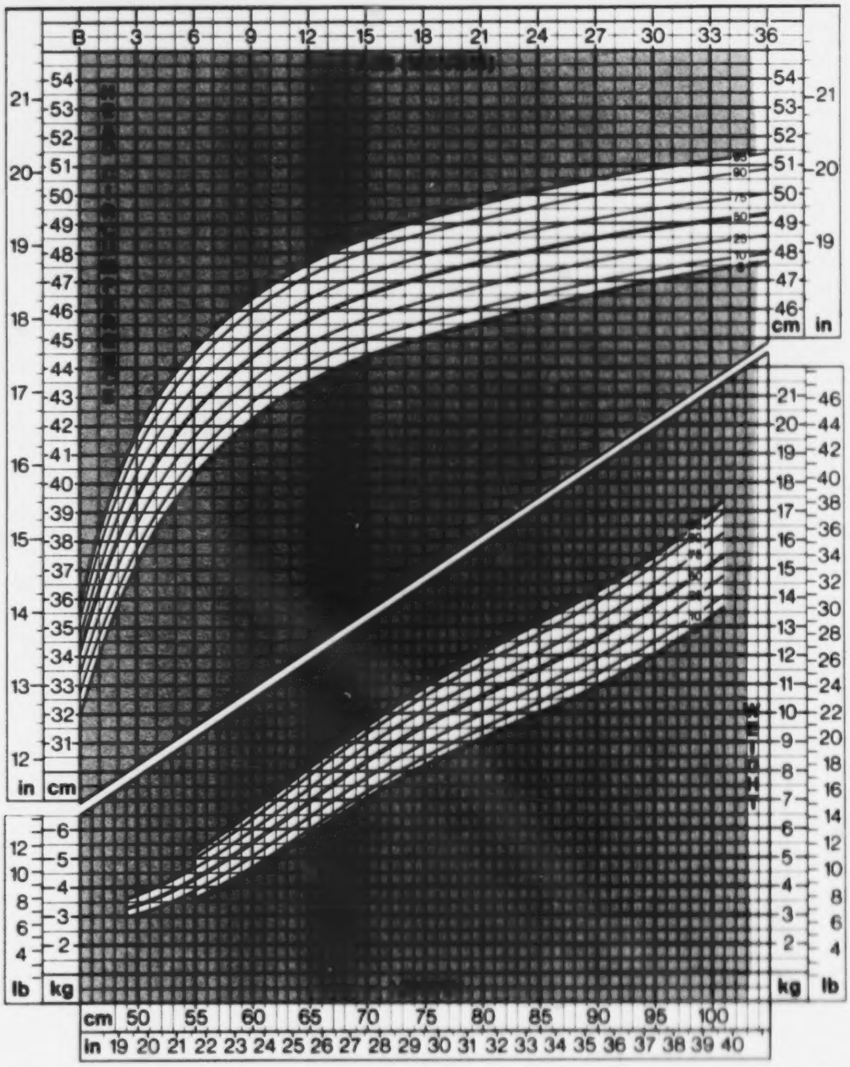
Preferable to cow milk during the first year
SIMILAC® WITH IRON Infant Formula
ADVANCE® Nutritional Beverage
For milk sensitivity
ISOMIL® Soy Isolate Formula
ROSS LABORATORIES
COLUMBUS, OHIO 43216
DIVISION OF ABBOTT LABORATORIES, USA

G107 January 1980

Appendix 11 (cont.,

GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________ RECORD # ______________



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Research Institute, Wright State University School of Medicine, Yellow Springs, Ohio

© 1980 ROSS LABORATORIES

DATE	AGE	LENGTH	WEIGHT	HEAD C
	BIRTH			

DATE	AGE	LENGTH	WEIGHT	HEAD C

Preferable to cow milk during the first year
SIMILAC® WITH IRON
Infant Formula

ADVANCE®
Nutritional Beverage

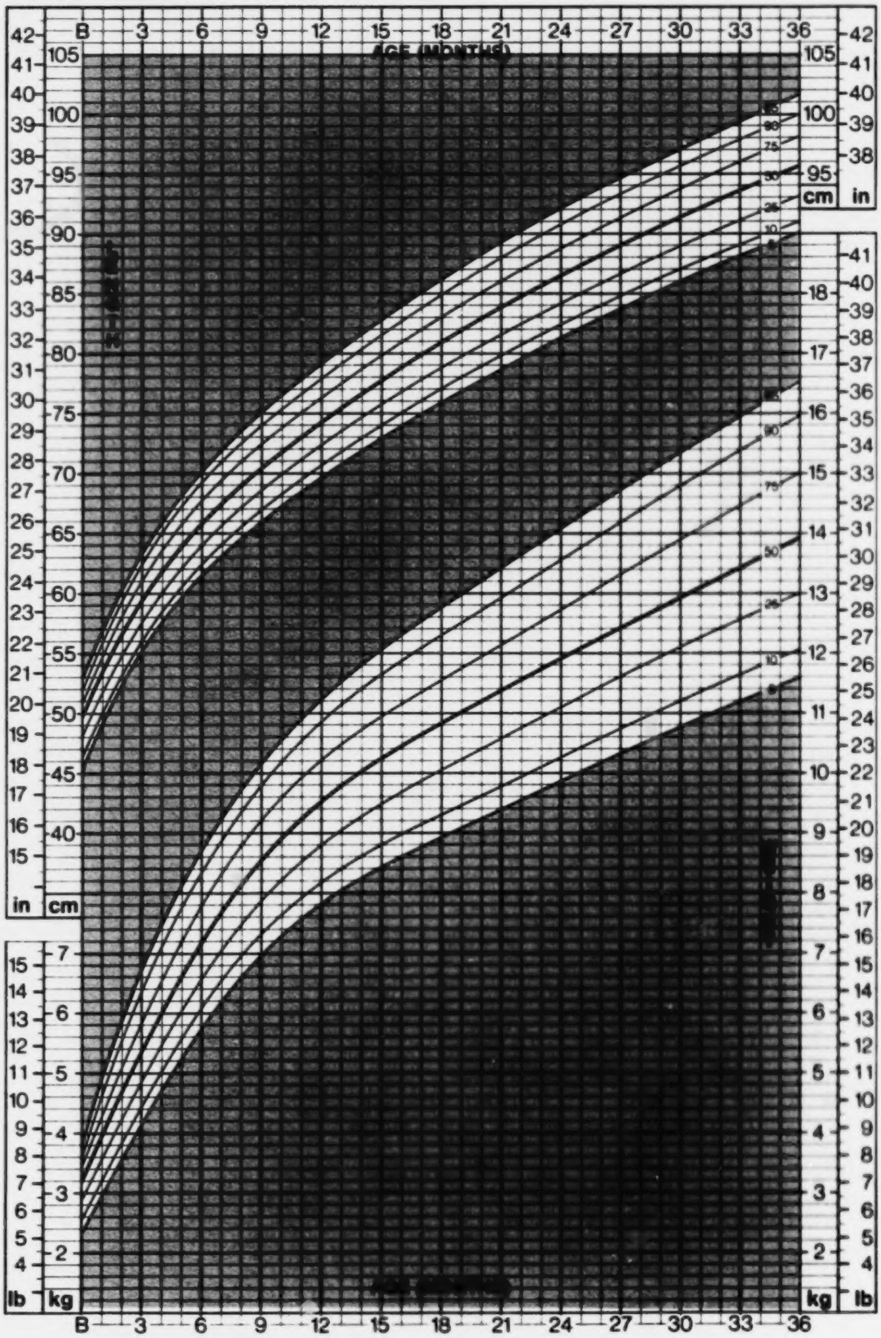
For milk sensitivity
ISOMIL®
Soy Protein Formula

ROSS LABORATORIES
COLUMBUS, OHIO 43216
DIVISION OF ABBOTT LABORATORIES USA

G106/JUNE 1981

GIRLS: BIRTH TO 36 MONTHS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ______________________ RECORD # ______________



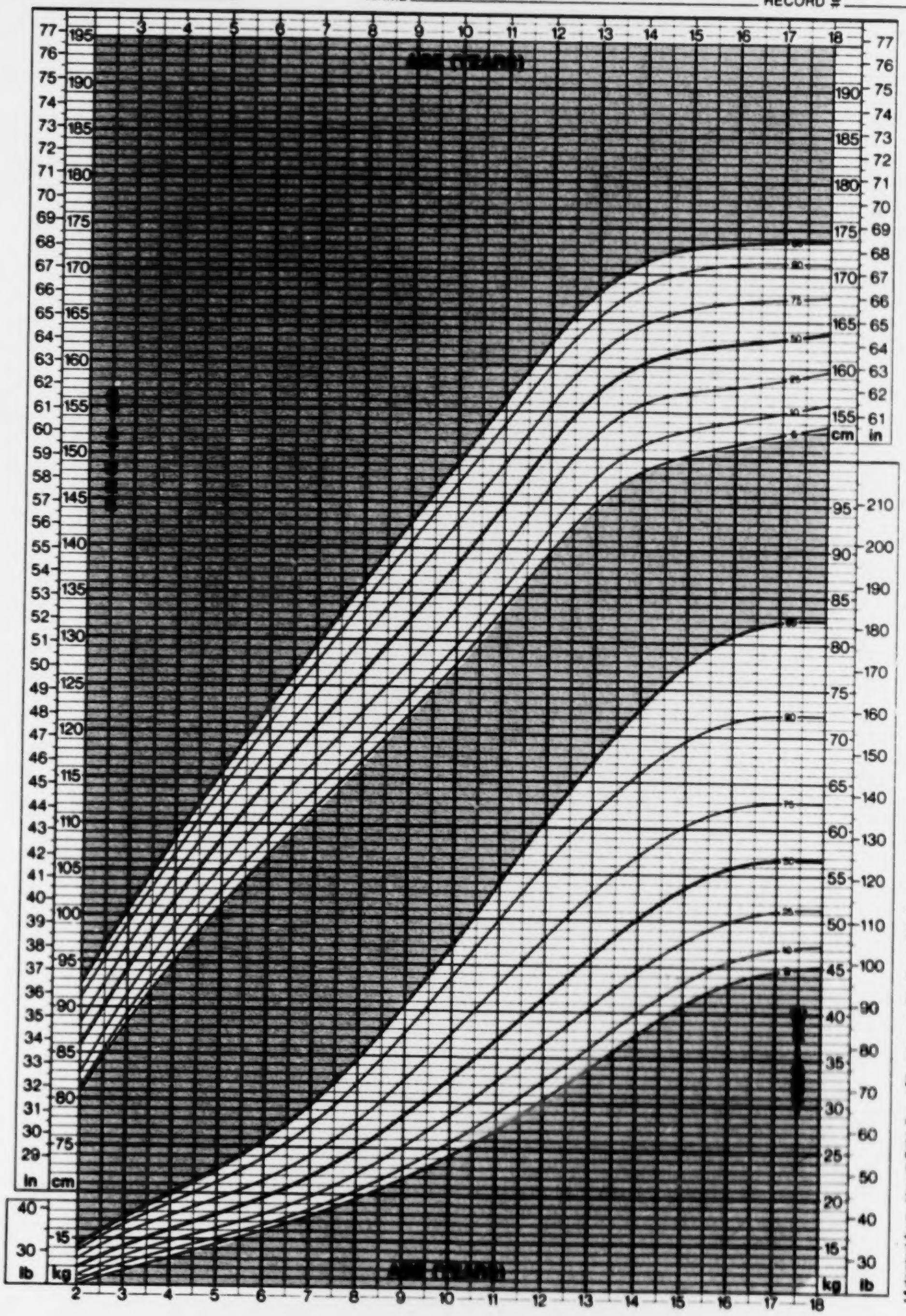
Ross Growth & Development Program

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the Fels Re[illegible]ch Institute, Wright State University School of Medicine, Yellow [illegible]gs, Ohio.

© 1980 ROSS LABORATORIES

GIRLS: 2 TO 18 YEARS
PHYSICAL GROWTH
NCHS PERCENTILES*

NAME ____________________ RECORD # ____________



Provided as a service of Ross Laboratories

*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629, 1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland.

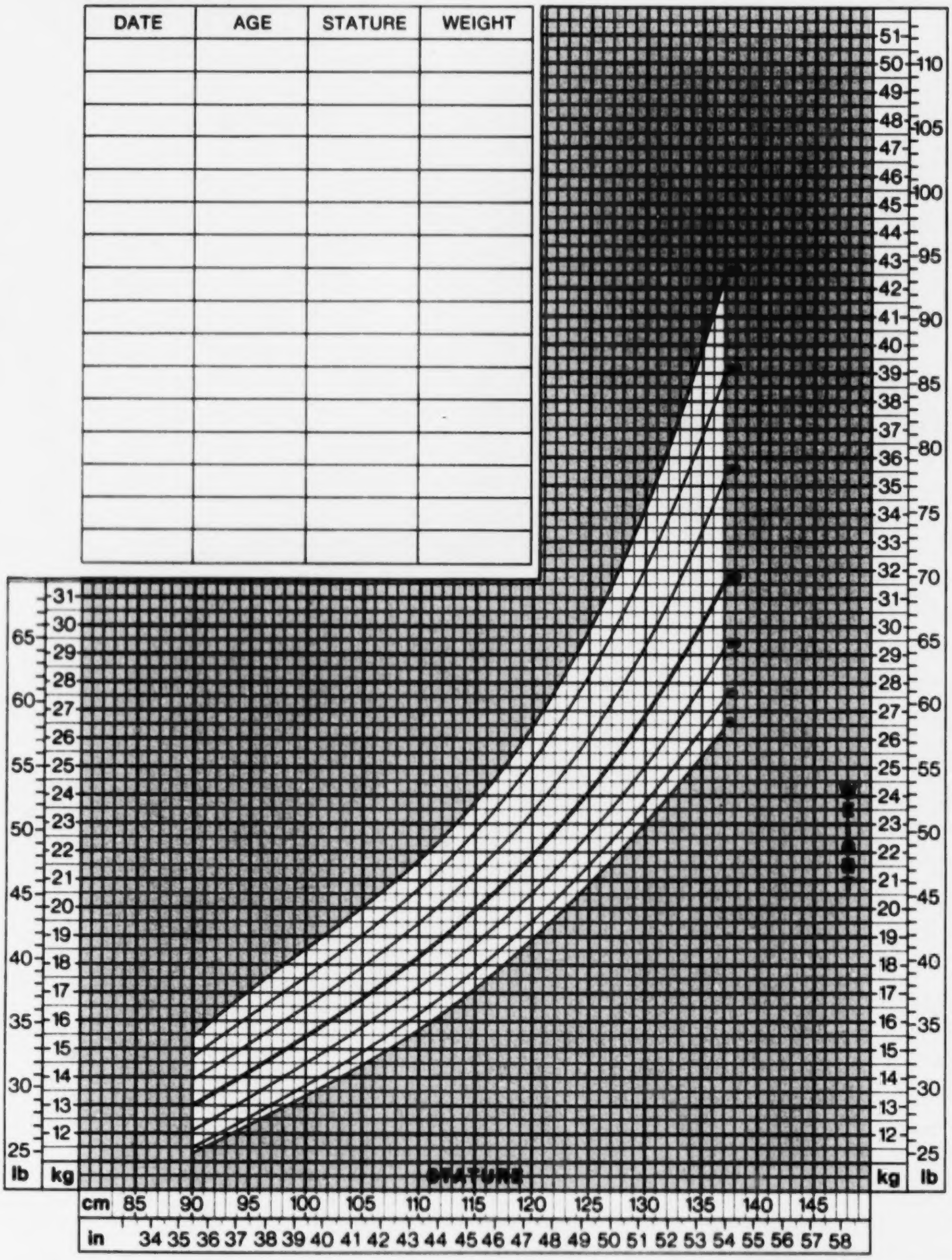
© 1980 ROSS LABORATORIES

Appendix 11 (cont.)

GIRLS: PREPUBESCENT PHYSICAL GROWTH NCHS PERCENTILES*

NAME ______________________ RECORD # ____________

DATE	AGE	STATURE	WEIGHT



*Adapted from: Hamill PVV, Drizd TA, Johnson CL, Reed RB, Roche AF, Moore WM: Physical growth: National Center for Health Statistics percentiles. AM J CLIN NUTR 32:607-629,1979. Data from the National Center for Health Statistics (NCHS) Hyattsville, Maryland

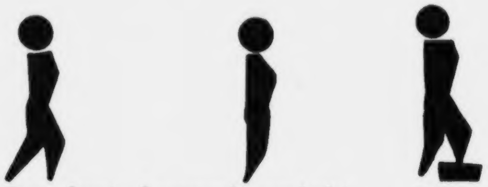
1980 ROSS LABORATORIES

Preferable to cow milk during the first year
SIMILAC® WITH IRON Infant Formula
ADVANCE® Nutritional Beverage
For milk-sensitivity
ISOMIL® Soy Isolate Formula
ROSS LABORATORIES
COLUMBUS, OHIO 43216
DIVISION OF ABBOTT LABORATORIES USA

G108 January 1980

Appendix 12

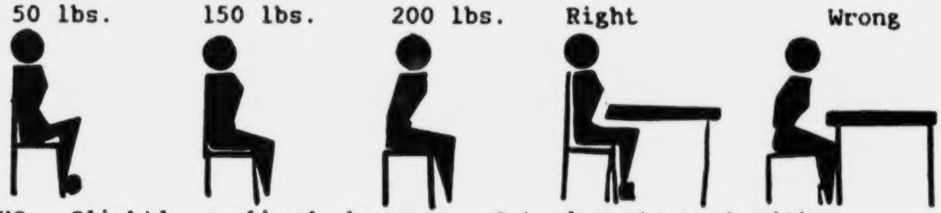
How to Care for Your Back



STANDING: One foot forward, weight on both legs, knees slightly bent.

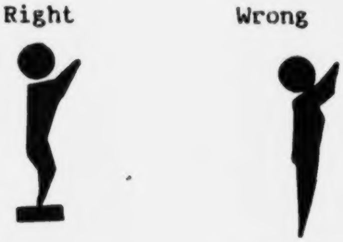
Put one foot up to change position.

Pressure on your back in each position equals:

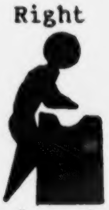

50 lbs.
150 lbs.
200 lbs.
Right
Wrong

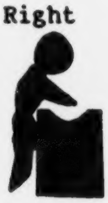
SITTING: Slightly reclined, knees higher than hips.

Get close to work with your chair, not your head.

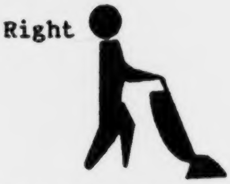

Right
Wrong

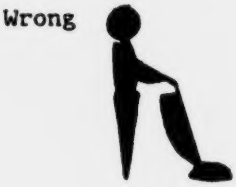
REACHING:

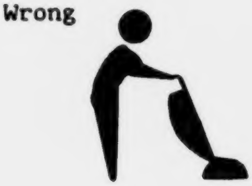




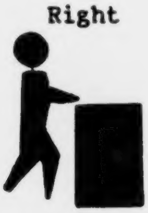
AT THE SINK: Bend and rest knees. or Open cabinet door and put one foot up.

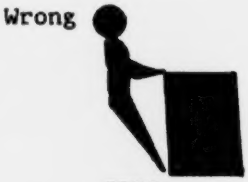




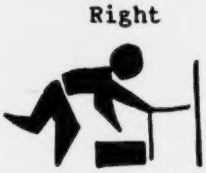


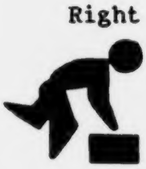
WEIGHT SHIFT AND DIAGONAL

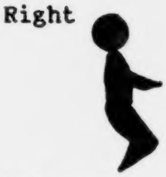


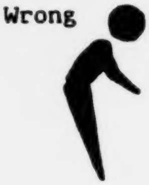


PUSH more than PULL

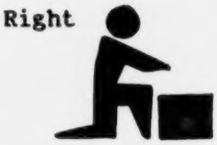


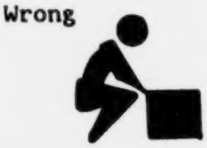




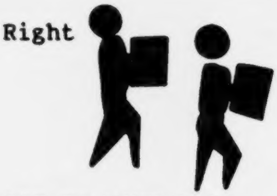


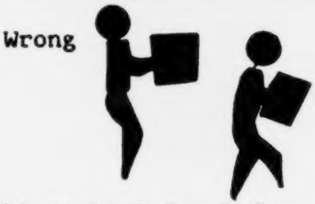
LIFTING: For light objects, leg in air; partial squat.



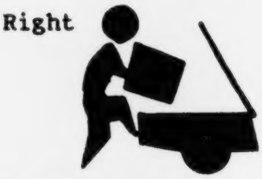


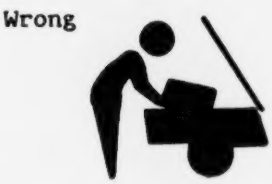
MORE LIFTING: Full squat with one foot forward.





KEEP THE LOAD CLOSE TO YOUR BODY: shift weight to back leg before walking.





USE THE BUMPER OF YOUR CAR

Appendix 13

Fluoridated Communities in Massachusetts

Fluoridated at 1 part fluoride per million parts water (ppm)

City/Town

Acton
Amesbury
Amherst
Andover
*Arlington
Ashburnham
Athol
Attleboro
Ayer (part) full 1988
Bedford
*Belmont
Belchertown School
Beverly
*Boston
Bourne (Otis A.N.G.)
*Brookline
*Cambridge (FL)
Canton
*Chelsea
Cohasset
Concord
Danvers
Dedham
Dighton (part)
Dracut
Duxbury
Essex
*Everett
Fall River
Fitchburg
*Framingham
Franklin
Gardner
Gloucester
Groveland (1988)
Hamilton
**Hardwick (part)
Haverhill
Hingham

City/Town

Holliston
Holyoke
Hudson
Hull
Ipswich
Lawrence
*Lexington
Lincoln
Longmeadow
Lowell
*Lynnfield (FL)
(Lynnfield Center)
Lynn
*Malden
Manchester
*Marblehead
Marlborough
Medford
Medway
*Melrose
Middleton
Millis (part) full 1987
*Milton
*Nahant
*Needham (FL)
Newbury (part)
Newburyport
*Newton (FL)
North Andover
North Reading
*Norwood
Oak Bluffs
Oxford
Peabody
Pembroke
*Quincy
Reading
*Revere
Rockport (part)

City/Town

**Royalston
Rutland
Salem
Saugus
Scituate
Seekonk
Sharon
Shrewsbury
Somerset
*Somerville
Southbridge
*Stoneham
Sturbridge (1988)
Sudbury
*Swampscott
Swansea
Taunton
Templeton
Tewksbury
Topsfield
Tyngsboro
*Wakefield
Walpole
*Waltham
**Ware (part)
*Watertown (FL)
Wenham
Wellesley
Westborough
Westminster
West Newbury (part)
*Weston (FL)
Westwood
Weymouth
*Winchester (FL)
*Winthrop
*Woburn (part)

* - Members of the Massachusetts Water Resources Authority, formerly Metropolitan Water District (MDC), fluoridated in 1978.
** - Naturally Fluoridated at .7 or higher ppm
(part) - Communities partially fluoridated. Check with local water department.

Appendix 14
Developmental Sequence of Feeding Skills

Age (months)	Oral & Neuromuscular Development	Feeding Skills/Implications	Special Notes
Birth to 1	Rooting Reflex	Will turn mouth toward nipple or object which brushes the cheek	Breast fed babies: need vitamin D and fluoride supplements.
	Sucking Reflex	Will begin sucking when lips are touched	
	Swallowing Reflex	Initially involves only the back of the tongue. By 9-12 weeks, the front will begin to become involved	Formula fed: no supplements needed
	Extrusion Reflex	Will push out any food placed on front of tongue	
2 to 4	Sucking Reflex becomes voluntary		
	Holds head erect		
	Mouth poises for nipple	Anticipates on sight of food/bottle	

Age (months)	Oral & Neuromuscular Development	Feeding Skills/Implications	Special Notes
4 to 6	Extrusion Reflex (tongue thrusting) diminishes, giving way to chewing motion	Begin introduction of solid foods as infant's need for calories and certain nutrients increases and cannot be provided by breast milk or formula alone.	Start with rice cereal. Prepare with 1 Tbsp. formula or breast milk. Gradually increase consistency as baby gets used to it.
	Beginning to reach mouth with hand		See Infant Feeding Guide (Appendix 15).
	Grasps objects voluntarily		
	Lateral motion of jaw and tongue	Tongue used to move food in mouth Texture of food may be increased	
	Sits with support		
6 to 8	Puts lips to rim of cup	Begin to offer beverages from a cup	Plain yogurt may replace some milk
	Puts most objects into mouth	Encourage finger foods	
	Grasps spoon, nipple, or cup rim	Removes food quickly from spoon with lips	
	Sits without support for brief periods		
	Beginning voluntary biting and early chewing	Increase texture to soft, mashed table foods Holds own bottle well	Strained, mashed, or bite-size pieces of soft, fresh or canned fruits and vegetables

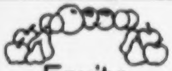
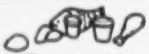
Appendix 14 (cont.)

Age (months)	Oral & Neuromuscular Development	Feeding Skills/Implications	Special Notes
8 to 10	Sits without support	Feeds self cracker	Wheat products may be started
			Begin meat and poultry, chopped or strained, and eggs
10 to 12	Chewing movements (up and down)	Gradually increase texture -- whole fruits and vegetables	May try small amounts of whole grain cereals
	Lips will close around rim of cup	Drinks from cup or glass with help	
	Neat pincer grasp	Finger foods -- small pieces	
	Cessation of drooling	Tries to use spoon	
12 to 18	Increased rotary motion of jaw	Tries to use spoon; give some thick foods that will stick to spoon	Cheese or yogurt may replace some of the milk
		Can chew meats	
		Drinks from cup	
	Growth rate slows considerably	Appetite decreased, may refuse food Provide small amounts	
	Increasing independence	Use spoon -- upside down	
		Mostly feeds self	
		Holds glass/cup with two hands	
		Bottle discarded	

Adapted from: Vermont Department of Health, Guidelines for Feeding Infants and Young Children.

Appendix 15
Infant Feeding Guide

INFANT FEEDING GUIDE

FOODS \ MONTHS	0–4 MONTHS	4–6 MONTHS	6–8 MONTHS	8–10 MONTHS	10–12 MONTHS
Breastmilk	Short frequent feedings 8 or more per day	Short frequent feedings 5 or more per day	On Demand 5 or more feedings	On Demand	On Demand
or Iron-Fortified Formula	16-32 ounces 5-10 feedings per day	24-40 ounces 4-7 feedings per day	24-32 ounces 3-4 feedings per day	16-32 ounces 3-4 feedings per day Can wean now from the bottle	16-24 ounces 3-4 feedings per day Whole milk can be offered now
Cereals & Bread	NONE	Boxed rice, oatmeal or barley (spoonfed) Mix 2-3 teaspoons with formula, water or breastmilk	Most varieties of boxed infant cereal Avoid cereals that are pre-mixed with formula, fruit or honey (1-4 tablespoons, twice a day)	Infant cereals, Cream of Wheat or other plain hot cereals Toast, bagel or crackers Good for teething	Hot or cold unsweetened cereals Bread Rice Noodles or spaghetti
Fruit Juices	NONE	Infant juice Adult apple juice Vitamin-C fortified (Avoid orange & tomato juice now) (2-4 ounces per day)	Infant juice Adult apple juice, Vitamin-C fortified Offer juice from a cup (4 ounces per day)	All 100% juices Orange and tomato juice can be offered now	All 100% juices from a cup
Vegetables	NONE	NONE	Strained or mashed vegetables Dark yellow or orange (avoid corn) Dark green (½-1 jar or ½ cup per day)	Cooked and mashed fresh or frozen vegetables	Cooked vegetable pieces May have some raw vegetables if child can chew them well
 **Fruits**	NONE	NONE	Fresh or cooked fruits Mashed bananas Applesauce Strained fruits (1 jar or ½ cup per day)	Peeled, soft fruit wedges Bananas, peaches, pears, oranges, apples	All fresh fruits, peeled and seeded Canned fruits, packed in water or its' own natural juice
 **Protein Foods**	NONE	NONE	Try plain yogurt Can be mixed with soft, fresh fruit or applesauce	Lean meat, chicken and fish (strained, chopped or small tender pieces) Egg yolk Yogurt Mild cheese Cooked dried beans	Small tender pieces of meat, fish or chicken Whole egg Cheese Yogurt Cooked dried beans Peanut butter

Massachusetts WIC Program   Nutrition Education Task Force   Revised 11/85   WIC Form #47

BEST COPY AVAILABLE

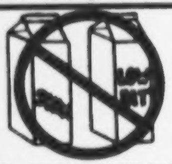
Some things to remember...

EVERY BABY IS DIFFERENT.
CONSULT YOUR DOCTOR OR NUTRITIONIST TO MAKE SURE YOUR BABY IS GETTING WHAT HE/SHE NEEDS.

A BABY'S BOTTLE IS FOR WATER, FORMULA AND 100% JUICE ONLY.

Poor eating habits may result from putting food in the bottle.

Avoid soda (tonic) and fruit drinks; Kool-aid, Hi-C, Hawaiian Punch, Zarex and Tang. They are full of sugar and food coloring.



WHEN YOU START TO OFFER MILK, USE WHOLE MILK.

Skim or lowfat milk should not be given to any child less than 2 years old because

- it does not have enough fat for the brain and nerves to grow;
- it may not have enough calories for growth.

DO NOT FEEL PRESSURED TO START SOLID FOODS BEFORE 4 MONTHS. THE BABY'S DIGESTIVE SYSTEM IS NOT YET FULLY DEVELOPED TO DIGEST SOLID FOODS.

YOU CAN MAKE YOUR OWN BABY FOODS. THEY COST LESS AND CAN BE BETTER FOR YOUR BABY.

- Sugar, butter and salt should not be added to your baby's food.
- Ask your nutritionist how to prepare your own baby foods.

NURSING BOTTLE SYNDROME

DON'T PUT YOUR BABY TO BED WITH A BOTTLE BECAUSE

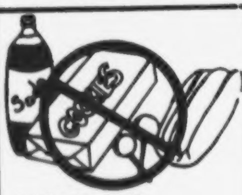
- it can cause ear infections,
- it can hurt their teeth by causing tooth decay (cavities) and
- it is a hard habit to break.

PLAIN
PLAIN

BUY PLAIN MEATS, VEGETABLES AND FRUITS - YOU GET MORE FOR YOUR MONEY.

- Combination dinners contain added water and starch fillers.
- You can mix meats and vegetables together if your baby prefers them that way.

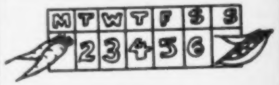
USE A BABY SIZE SPOON TO FEED YOUR BABY SMALL AMOUNTS AT FIRST.
MAKE THE FOOD THIN AND SMOOTH BY MIXING IT WITH A LITTLE FORMULA, BREASTMILK OR WATER.



FOODS TO AVOID

- MIXED DINNERS
- BACON, LUNCHEON MEATS, HOT DOGS, HAM
- CREAMED VEGETABLES
- FRUIT DESSERTS
- PUDDINGS
- COOKIES, CANDY, CAKES
- SWEETENED DRINKS

These foods are high in fat and sugar and contain few nutrients for your money.


M T W T F S S
2 3 4 5 6

ADD ONE NEW FOOD AT A TIME. WAIT ABOUT 5 DAYS BEFORE YOU TRY ANOTHER ONE.

- This will give your baby time to get used to the new food.
- If your baby has a reaction, you will know which food caused it.

THE BEST FOODS

- PLAIN FRUIT
- PLAIN MEATS
- PLAIN VEGETABLES
- EGGS
- 100% FRUIT JUICES
- UNSALTED CRACKERS
- RICE
- NOODLES, SPAGHETTI
- WHOLE WHEAT BREAD
- HOT OR COLD UNSWEETENED CEREALS
- PLAIN YOGURT
- COTTAGE CHEESE

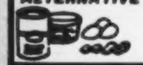
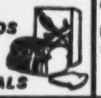
MASSACHUSETTS WIC PROGRAM

[illegible] is an Equal Opportunity Program. If you believe you have been discriminated against because of race, [illegible] national origin, age, sex, or handicap, write immediately to the Secretary of Agriculture, Washington, [illegible]

WIC Form #47

Appendix 16
Preschool Feeding Guide

PRE-SCHOOL FEEDING GUIDE

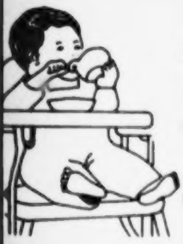
FOOD GROUP	MAJOR NUTRIENTS	FOOD SOURCES	MINIMUM NUMBER OF SERVINGS PER DAY	SERVING SIZES FOR SMALL CHILDREN	
				1-3 Years	3-5 Years
MILK & MILK PRODUCTS	CALCIUM PROTEIN	Whole, lowfat, skim or evaporated milk mixed with water, plain yogurt, cheese NOTE: Lowfat and skim milk should not be given before 2 years of age.	3 (20-24 ounces)	3/4 - 1 cup milk (3/4 cup or 6 ounces of milk = 1 ounce of cheese = 3/4 cup plain yogurt)	
MEAT OR MEAT ALTERNATIVE 	PROTEIN IRON	Lean meat, fish, poultry, liver, eggs Dried peas or beans, nuts, peanut butter, tofu	2	1 ounce meat, fish or poultry or 1/2 cup peas or beans or tofu or 2 tablespoons peanut butter (1 egg = 1 serving)	1 1/2 ounces meat or 3/4 cup peas or beans or 3 tablespoons peanut butter
*** VEGETABLES & FRUITS**	VITAMIN A	Carrots, sweet potatoes, greens, winter squash, broccoli, mango, cantaloupe [Minimum 1 serving per day]	4	2-4 tablespoons (1/8 - 1/4 cup)	
	VITAMIN C	Oranges, grapefruit, orange juice, grapefruit juice, tangerines, papaya, strawberries, green pepper, broccoli, brussel sprouts [Minimum 1 serving per day]		1/2 cup or 1 small piece	
	OTHER VITAMINS & MINERALS	Potatoes, corn, green beans, peas, lettuce, cabbage, cucumbers, tomatoes, apples, bananas, grapes, plums, peaches		1/4 cup or 1/2 small piece	
*** BREADS & CEREALS** 	CARBOHYDRATE B-VITAMINS IRON - (if enriched or fortified)	Whole wheat or enriched white bread, macaroni or spaghetti, rice, cold or hot unsweetened cereals	4	1/2 slice of bread 1/4 cup rice, macaroni or dry cereal 1-2 tablespoons hot cereal	1 slice of bread 1/2 cup of rice, macaroni or dry cereal 3-5 tablespoons hot cereal
FATS, OILS & SUGAR	FAT SUGAR	Margarine, butter, vegetable oils, lard, mayonnaise, salad dressing, bacon, sausages, salt pork, candy, cookies, chips, Kool-aid, soda (tonic), fruit punch	TO BE USED IN LIMITED AMOUNTS... These foods are high in calories, sugar, fat and salt.		

*NOTE: Most fruits, vegetables and whole grain foods are high in fiber.

MASSACHUSETTS WIC PROGRAM WIC Form #51

SOME THINGS TO REMEMBER...

BUILD GOOD EATING HABITS



- Make sure your child is sitting in a comfortable eating place.
- It is easier for a child to use a plastic cup filled only half way.
- A small bowl will help the child to get the food onto a spoon.
- Try one new food at a time. Offer it at the beginning of a meal when the child is most hungry.
- Offer foods that your child can eat with his or her fingers like pieces of vegetables, fruits, meat, cheese, crackers or cereal.
- Learning to eat takes practice... be prepared for spills.

REMEMBER:

- Every child is different! Talk to your doctor or nutritionist to make sure your child is getting what he or she needs.
- Children need the same good, nutritious foods as adults, only they don't need as much.
- Good eating begins at home. Remember what you buy is what you eat.

VEGETABLES

Vegetables are important and can be fun to eat. However, many children refuse them.

- Try them raw

  Cut and clean them ahead of time so they are ready to eat. Eat them plain or dip them in yogurt, cottage cheese or peanut butter.
- Try them cooked

  Put them in a stew, soup, spaghetti sauce or meatloaf.

100%
NO SUGAR ADDED

JUICES

- Any drink that is not plain water contains sugar. Large amounts of sugar can decay teeth.
- Drinks such as Kool-aid, Hawaiian Punch, Hi-C, soft drinks, Zarex and fruit drinks are mainly sugar and water. Some contain vitamin C but they should not replace 100% FRUIT JUICES which have many other vitamins and minerals.

When shopping, look for

*** 100% FRUIT JUICE**

*** NO SUGAR ADDED**

on the label.

KEEP TEETH HEALTHY

TOOTHPASTE

- Teach your child to brush his or her teeth after meals and snacks. When brushing is not possible, have your child rinse his or her mouth with water.
- Avoid sticky food such as candy and raisins, especially between meals.
- Take your child to the dentist between the ages of 3 and 4. If your child has tooth decay, GO IMMEDIATELY.
- Visit your dentist every 6 months for cleaning, a check-up and if needed, a fluoride treatment.

Nutritionist's Comments:

"This is an Equal Opportunity Program. If you believe you have been discriminated against because of race, color, national origin, age, sex, or handicap, write immediately to the Secretary of Agriculture, Washington, D.C. 20250."

MASSACHUSETTS WIC PROGRAM NUTRITION EDUCATION TASK FORCE Revised 11/85

Appendix 17

Sample Weekly Menus

WEEK ONE

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
BREAKFAST	Orange juice-1/2 cup Scrambled egg-1 Biscuit-1 small Margarine-1 tsp. Milk-3/4 cup	Sliced banana-1/2 cup Corn flakes-1/3 to 1/2 cup Milk-3/4 cup	Apricot halves-1/2 cup Blueberry muffin-1/2 muffin Margarine-1 tsp. Milk-3/4 cup	Fruit cup-1/2 cup Hard cooked egg Toast-1/2 to 1 slice Margarine-1 tsp. Milk-3/4 cup	Grapefruit sections-1/2 cup Oatmeal with raisins-1/3-1/2 cup Milk-3/4 cup
A.M. SNACK	Cinnamon toast-1/2 to 1 slice Margarine-1 tsp. Milk-1/2 cup	Pineapple chunks-1/2 cup Graham cracker-1-2 Cream cheese-2 tsp.	Yogurt-1/2 cup Applesauce-1/4 cup	Rye crackers-2 Cottage cheese-1/4 cup Orange juice-1/2 cup	Enriched soda crackers-2 Peanut butter-1 Tbsp. Milk-1/2 cup
LUNCH	Meat loaf-1 slice (1-1/2 oz meat) Green beans-1/4 cup Pineapple cubes-1/4 cup Bread-1/2-1 slice Margarine-1 tsp. Milk-3/4 cup	Baked chicken-(1-1/2 oz. meat) Mashed potatoes-1/4 cup Peas-1/4 cup Roll-small Margarine-1 tsp. Milk-3/4 cup	Chicken vegetable soup-1/2 cup(1 oz. meat, 1/4 c. vegs.) Peanut butter(1 Tbsp) and jelly sandwich-1/4 to 1/2 Carrot sticks Sliced peaches-1/4 c. Milk-3/4 cup	Spaghetti and meat sauce-1/2 cup(1-1/2 oz. meat) Sweet red or green pepper slices-2 Green salad-1/4 cup French bread-1/2 slice Milk-3/4 cup	Fish sticks-3 (1-1/2 oz. fish) Spinach-1/4 cup Fresh pear half-1/4 cup Corn bread-1 square Milk-3/4 cup
P.M. SNACK	Mixed fruit juice-1/2 cup Celery sticks with peanut butter-2	Milk-1/2 cup Oatmeal cookie-1	Apple juice-1/2 cup Soft pretzel-1	Milk-1/2 cup Peanut butter cookie-1	Cottage cheese dip-1/4 cup Zucchini sticks Melba toast-3 pieces

WEEK TWO

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
BREAKFAST	Sliced peaches-1/2 cup Unsweetened iron-fortified cereal-1/3-1/2 cup Milk-3/4 cup	Apple juice (fortified with Vitamin C)-1/2 cup Scrambled egg-1 Whole wheat toast-1/2-1 slice Margarine-1 tsp. Jelly-1 tsp. Milk-3/4 cup	Orange juice-1/2 cup Corn muffin-1/2-1 Margarine-1 tsp. Milk-3/4 cup	Orange sections-1/2 cup Cottage cheese-1/4 cup Raisin toast-1/2-1 slice Margarine-1 tsp. Milk-3/4 cup	Fruit cup-1/2 cup French toast with cinnamon-1/2-1 slice Margarine-1 tsp. Maple syrup-1 tsp. Milk-3/4 cup
A.M. SNACK	Graham crackers-2 Peanut butter-2 tsp. Milk-1/2 cup	Unsweetened iron-fortified cereal-1/3-1/2 cup Milk-1/2 cup	Rye wafers-2 or 3 Peanut butter-2 tsp. Milk-1/2 cup milk	Graham crackers-2 Cream cheese-2 tsp. Milk-1/2 cup	Unsweetened iron-fortified cereal-1/3-1/2 cup Sliced banana-1/2 cup Milk-1/2 cup

Appendix 17 (cont.)

LUNCH	Tuna sandwich (1/2 cup tuna with 1 tsp. mayonnaise, 1 slice bread) 2 fruit slices (pear apple, or orange) Milk-3/4 cup	Macaroni and cheese 1/3-1/2 cup Tomato wedges 2-3 Raisins-1 tbsp. Milk-3/4 cup	American chop suey-1/2 cup Spinach salad-1/4 cup Pineapple chunks-1/4 cup Milk-3/4 cup	Meatball sub-1 1/2 oz. with cheese-1/8 cup Tossed salad-1/4 cup Fruit cup-1/4 cup Milk-3/4 cup	Home made turkey soup-1/2 cup Pumpernickel bread-1/2-1 slice Apple crisp w/cheese-1/2 cup Milk-3/4 cup
P.M. SNACK	Plain yogurt-1/2 cup mixed with Banana-1/2 cup, mashed Orange juice-1/2 cup	Celery stuffed with peanut butter-2 Milk-1/2 cup	Unsweetened iron-fortified cereal-1/3-1/2 cup Sliced banana-1/2 cup Milk-1/2 cup	Grape juice-1/2 cup Vanilla yogurt-1/2 cup Bran muffin-1/2	Oatmeal cookie-1 Milk-1/2 cup

WEEK THREE

	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
BREAKFAST	Pineapple juice-1/2 cup Oatmeal with raisins-1/2 cup Milk-3/4 cup	Citrus fruit cup-1/2 cup Poached egg-1 Toast-1/2-1 slice Margarine-1 tsp. Milk-3/4 cup	Orange sections-1/2 cup English muffin-1/2-1 Cheese cubes-1 oz. Milk-3/4 cup	Orange juice-1/2 cup Bran muffin-1/2-1 Peanut butter-1 tsp. Milk-3/4 cup	Fresh berries (in season)-1/4 cup Unsweetened iron fortified cereal-1/2 cup Milk-3/4 cup
A.M. SNACK	Plain yogurt-1/2 cup Applesauce-1/4 cup	Bagel-1/2 Peanut butter-1 Tbsp. Milk-1/2 cup	Crackers-2 to 4 Fruit juice-1/2 cup	Oatmeal cookies-1 Milk-1/2 cup	Enriched soda crackers-2 Cheese-1 slice Milk-1/2 cup
LUNCH	Chili con carne-1/4-1/2 cup Bread 1/2-1 slice Margarine-1 tsp. Pudding-1/2 cup Milk-3/4 cup	Chicken rice soup-1/2 cup Cheese sandwich-1/2 Assorted vegetable sticks-1/2 cup Orange wedges-1/4 cup Milk-3/4 cup	Tuna noodle casserole-1/2 cup Green beans-1/4 cup Carrot sticks-1/4 cup Fruit cup-1/4 cup Milk-3/4 cup	Beef stew-1/2 cup Fresh garden vegetable-1/2 cup Whole wheat bread-1/2 to 1 slice Ice cream-1/4 cup Milk-3/4 cup	Turkey sandwich (1 oz. turkey, 1 tsp. mayonnaise-1/2-1 slice bread) Sweet red or green pepper slices-2 Graham crackers-2 Milk-3/4 cup
P.M. SNACK	Cheese toast (melt on 1/2 slice bread) Orange juice-1/2 cup	Bread pudding-1/3 cup Pineapple juice-1/2 cup	Banana bread-1 slice Milk-1/2 cup	Crackers and cheese-2 to 4 Apple juice-1/2 cup	Raisin bread-1/2 slice Peanut butter-1 Tbsp. Fresh fruit-1/2 cup

Appendix 18

Facts About the Child Care Food Program

The Child Care Food Program (CCFP) provides nutritious meals to children enrolled in child care centers or family day care homes throughout the country. It also introduces young children to many different types of foods and helps teach them good eating habits.

■ WHO CAN PARTICIPATE?

The Program is limited to public and private nonprofit organizations providing licensed or approved nonresidential day care services. Such organizations include, but are not limited to, child care centers, outside-school-hours care center programs, family day care homes, and institutions providing day care services for handicapped children. Also, private for-profit centers may qualify if they receive compensation under Title XX of the Social Security Act for at least 25 percent of the children who are receiving nonresidential day care.

Child care centers and outside-school-hours care centers can operate in the program either independently or through a sponsoring organization which accepts final administrative and financial responsibility for the program. Family day care homes must participate under a sponsoring organization (they cannot enter the CCFP directly).

Children 12 years and younger are eligible to participate in the program. (For children of migrant workers, the age limit is 15 years). Physically or mentally handicapped people are eligible regardless of age, if they receive care at a center or home where the majority of the enrollees are 18 years or under.

■ ELIGIBILITY REQUIREMENTS

All private institutions (except for-profit Title XX organizations) must have tax-exempt status under the Internal Revenue Code of 1954, or must have applied to the Internal Revenue Service (IRS) for it at the time they apply for the Child Care Food Program. If an institution takes part in other Federal programs for which it needs nonprofit status, it already meets this requirement. Family day care homes are not required to be tax exempt but their sponsoring organizations must have tax-exempt status if they are private. Local IRS offices can provide information on how to obtain tax-exempt status.

(All institutions, except sponsoring organizations, must have child care licensing or approval.)

MEAL SERVICE

All participating institutions must serve meals that meet U.S. Department of Agriculture nutritional standards. Institutions may receive payment for up to three meals per child per day; one of these meals must be a snack.

AVAILABLE ASSISTANCE

The CCFP provides financial assistance to child care centers and sponsoring organizations of day care homes so that they can provide nutritious meals to the children enrolled for care.

Generally, program payments to child care centers and outside-school-hours care centers are limited to the number of meals served to participating children multiplied by the appropriate rates for reimbursement. The rate of payment varies according to the family size and income of children participating in the program. Increased payment is provided for needy children.

Meals served by day care homes under CCFP are paid for at different rates for each type of meal served meeting program requirements. The sponsoring organization must pass the full food service payment to the home, unless the sponsoring organization provides part of the home's food service. Day care home providers receive payment for meals served to their own children only when (1) their children meet the family size and income standards for free and reduced-price meals and are participating in the CCFP, and (2) other nonresident enrolled children are present and participating in the program. Separate administrative funds are provided to sponsoring organizations based on the number of homes they administer.

CIVIL RIGHTS

The CCFP is available to all eligible children regardless of race, color, national origin, sex, age, or handicap. If you believe that you have been treated unfairly in receiving food services for any of these reasons, write immediately to the Secretary of Agriculture, Washington, D.C. 20250. More information may be obtained from the Office of Equal Opportunity, U.S. Department of Agriculture, Washington, D.C. 20250.

ADMINISTERING AGENCY

In Massachusetts, the Child Care Food Program is administered by the State Department of Education. For more details on CCFP, contact:

Commonwealth of Massachusetts
Department of Education
Bureau of School Nutrition Services
1385 Hancock Street
Quincy, MA 02169
(617) 770-7260

Appendix 19

Massachusetts Cooperative Extension Service Extension Food and Nutrition Education Programs (EFNEP)

BARNSTABLE COUNTY (617) 362-2511 Ext. 585
Cape Cod Cooperative Extension
Deeds and Probate Building
Railroad Avenue
Barnstable, MA 02630

BERKSHIRE COUNTY (413) 448-8285
Berkshire County Cooperative Extension
46 Summer Street
Pittsfield, MA 01201

BRISTOL COUNTY (617) 669-6744
Bristol County Cooperative Extension
135 Center Street
Segreganset, MA 02715

DUKES COUNTY (617) 693-0694
Dukes County Cooperative Extension
P.O. Box 1696
Oak Bluffs, MA 02557

ESSEX COUNTY (617) 777-8720
Essex County Cooperative Extension
562 Maple Street
Hathorne, MA 01937

FRANKLIN COUNTY (413) 774-2902
Franklin County Cooperative Extension or 774-2903
Taylor Block
238 Main Street
Greenfield, MA 01301

HAMPDEN COUNTY (413) 736-7204
Hampden County Cooperative Extension or 737-0236
425 Union Street
West Springfield, MA 01089

HAMPSHIRE COUNTY (413) 584-2556
Hampshire County Cooperative Extension
15 Straw Avenue
Northampton, MA 01060

Appendix 19 (cont.)

MIDDLESEX COUNTY (617) 369-4845
Middlesex County Coopertive Extension or 862-2380
105 Everett Street
Concord, MA 01742

NORFOLK COUNTY (617) 769-8356
EFNEP Nutrition Education Program (617) 479-6056
J.F.K. Health Center
120 Hancock Street
Quincy, MA 02169

Norfolk County Cooperative Extension or 769-8355
460 Main Street or 668-9795
Walpole, MA 02081

PLYMOUTH COUNTY (617) 583-2545
EFNEP Nutrition Education Program
32 Belmont Street
Brockton, MA 02401

Plymouth County Cooperative Extension (617) 447-5946
P.O. Box 658 (617) 293-3541
High Street
Hanson, MA 02341

SUFFOLK COUNTY (617) 727-4107
Suffolk County Cooperative Extension
150 Causeway Street, Room 803
Boston, MA 02114

WORCESTER COUNTY
EFNEP Nutrition Education Program (617) 757-1860
10 Edward Street
Worcester, MA 01605

EFNEP Nutrition Education Program (617) 537-7327
26 Main Street, 3nd Floor
Leominster, MA 01433

Worcester County Cooperative Extension (617) 892-1116
P.O. Box 0248
759 Main Street
Leicester, MA 01524

Appendix 20
Department of Social Services Area Offices

DSS REGION I OFFICE

145 State Street
Springfield, MA 01103
(413) 781-0323

AREA 1	PITTSFIELD AREA OFFICE 141 North Street Pittsfield, MA 01201	(413) 499-7370
AREA 2	GREENFIELD AREA OFFICE 25-27 Bank Row Greenfield, MA 01301	(413) 774-5546
AREA 2A	NORTHHAMPTON AREA OFFICE 240 Main Street Memorial Hall Northampton, MA 01060	(413) 586-8480
AREA 3	HOLYOKE/CHICOPEE AREA OFFICE 113-127 Hampden Street Holyoke, MA 01040	(413) 536-4762
AREA 4	SPRINGFIELD AREA OFFICE 365 Bay Street Springfield, MA 01109	(413) 781-0881
AREA 5	WESTFIELD AREA OFFICE 2 Free Street Westfield, MA 01085	(413) 562-9681

DSS REGION II OFFICE

Midtown Mall 3rd & 4th Floors 22 Front Street Worcester, MA 01608	Mailing Address: Midtown Mall P.O. Box 74 Worcester, MA 01608	(617) 798-8171

AREA 6	FITCHBURG AREA OFFICE 435 Main Street, Suite 3100 Fitchburg, MA 01420	(617) 345-2101
AREA 7	GARDNER AREA OFFICE 196 Main Street Gardner, MA 01440	(617) 632-9104

DSS REGION II - CONT.

AREA 8	BLACKSTONE VALLEY AREA OFFICE 185 Church Street Whitinsville, MA 01588	(617) 234-6213
AREA 9	SOUTH CENTRAL AREA OFFICE P.O. Box 797 253 Main Street Webster, MA 01570	(617) 949-0113
AREA 10	WORCESTER AREA OFFICE 340 Main Street Worcester, MA 01608	(617) 791-1200

DSS REGION III OFFICE

143 South Main Street Middleton, MA 01949	(617) 777-4420

AREA 11	LOWELL AREA OFFICE 685 Lawrence Street Lowell, MA 01852	(617) 452-8970
AREA 12	LAWRENCE AREA OFFICE 11 Lawrence Street, 4th Fl. Lawrence, MA 01840	(617) 685-8384
AREA 13	HAVERHILL AREA OFFICE 200 Main Street Haverhill, MA 01830	(617) 373-3913
AREA 14	CAPE ANN AREA OFFICE 197 R Cabot Street Beverly, MA 01915	(617) 927-4600
AREA 15	DANVERS/SALEM AREA OFFICE 209 Essex Street, 3rd Fl. Salem, MA 01970	(617) 741-0440

DSS REGION III - CONT.

AREA 16	LYNN AREA OFFICE 181A Union Street Lynn, MA 01901	(617) 596-0200
AREA 16A	CHELSEA AREA OFFICE 300 Broadway Chelsea, MA 02150	(617) 889-3820
AREA 17	EASTERN MIDDLESEX AREA OFFICE Crystal Lake Office Park 4 Rail Road Avenue Wakefield, MA 01880	(617) 245-2754
AREA 18	TRI-CITY AREA OFFICE 40 Eastern Avenue Malden, MA 02148	(617) 321-0130

DSS REGION IV OFFICE

810 Memorial Drive, Level One (617) 868-1400
Cambridge, MA 02139

AREA 19	CONCORD AREA OFFICE 201 Great Road Acton, MA 01720	(617) 263-8159
AREA 20	ARLINGTON (Woburn) AREA OFFICE 20 Academy Street Arlington, MA 02174	(617) 641-1780
AREA 21	BEAVERBROOK AREA OFFICE 411 Waverly Oaks Road Waltham, MA 02154	(617) 894-8770
AREA 22	CAMBRIDGE/SOMERVILLE AREA OFFICE 259 Elm Street Somerville, MA 02144	(617) 625-9170
AREA 23	MARLBOROUGH AREA OFFICE Walker Building, Rm. 203 255 Main Street Marlborough, MA 01752	(617) 481-2640

DSS REGION IV - CONT.

AREA 24	FRAMINGHAM AREA OFFICE 354 A Waverly Street Framingham, MA 01701	(617) 872-8122
AREA 25	NEWTON AREA OFFICE 437 Cherry Street West Newton, MA 02165	(617) 965-2607
AREA 26	NORWOOD AREA OFFICE 1416 Boston/Providence Highway Norwood, MA 02062	(617) 769-8780
AREA 27	QUINCY AREA OFFICE 1419 Hancock Street Quincy, MA 02169	(617) 773-8920
AREA 28	COASTAL AREA OFFICE Stetson Place 541 Main Street South Weymouth, MA 02190	(617) 331-6600

DSS REGION V

141 Main Street Brockton, MA 02401	(617) 587-8110

AREA 29	ATTLEBORO AREA OFFICE 67 Mechanic Street PO Box 239 Attleboro, MA 02703	(617) 226-4553
AREA 30	BROCKTON AREA OFFICE 143 Main Street Brockton, MA 02401	(617) 584-0980
AREA 31	PLYMOUTH AREA OFFICE Industrial Park Road Ext. Plymouth, MA 02360	(617) 585-6533
AREA 32	TAUNTON AREA OFFICE 21 Spring Street Taunton, MA 02780	(617) 822-7761
AREA 33	FALL RIVER AREA OFFICE 240 Elm Street Fall River, MA 02720	(617) 675-1145

DSS AREA OFFICES

DSS REGION V - CONT.

AREA 34	NEW BEDFORD AREA OFFICE 9 South Sixth Street New Bedford, MA 02740	(617) 997-3361
AREA 34A	WAREHAM AREA OFFICE 215 Sandwich Road Wareham, MA 02571	(617) 295-2501
AREA 35	CAPE AND ISLANDS AREA OFFICE 467 B Station Avenue South Yarmouth, MA 02664	(617) 394-1325

DSS REGION VI

150 Causeway Street, 8th Floor (617) 367-2040
Boston, MA 02114

AREA 36	"BOSTON STATE" AREA OFFICE 123 Morton Street Jamaica Plain, MA 02130	(617) 524-5474
AREA 37	BOSTON/BROOKLINE AREA OFFICE 77 Warren Street West Hall Building 9 Brighton, MA 02135	(617) 783-1640
AREA 38	SOLOMON CARTER FULLER MENTAL HEALTH CENTER 85 East Newton Street Boston, MA 02118	(617) 266-9298
AREA 38A	BOSTON UNIVERSITY AREA OFFICE 55 Dimock Street Roxbury, MA 02119	(617) 445-5485
AREA 39	TUFTS BAY COVE AREA OFFICE 1448-1452 Dorchester Avenue One Fields Corner Dorchester, MA 02122	(617) 288-0300
AREA 40	HARBOR AREA OFFICE 115 Gove Street East Boston, MA 02128	(617) 569-8310

DSS AREA OFFICES

DSS REGION VI - CONT.

AREA 40A	CHARLESTOWN AREA OFFICE 76 Monument Street Charlestown, MA 02129	(617) 242-3477
AREA 40B	TEMPORARY HOME FOR WOMEN AND CHILDREN 41 New Chardon Street Boston, MA 02114	(617) 523-2337

Appendix 21
Office for Children Area Offices

REGION I

15 Mulberry Street
Springfield, MA 01105
(413) 788-8401

Hampshire Council for Children
12-26 Market Street
Northampton, MA 01060

Child Advocate (413) 584-7970/71/72
Community Representative (413) 584-7970/71/72

Amherst
Chesterfield
Cummington
Easthampton
Goshen
Hadley
Hatfield
Middlefield
Northampton
Pelham
Plainfield
Westhampton
Williamsburg
Worthington

……

Berkshire Council for Children
150 North Street, Pittsfield, MA 01201

Child Advocate (413) 499-4492
Community Representative (413) 499-1968

Adams
Alford
Becket
Cheshire
Clarksburg
Dalton
Egremont
Florida
Great Barrington
Hancock
Hinsdale
Housatonic
Lanesborough
Lee
Lenox
Monterey
Mount Washington
New Ashford
New Marlborough
North Adams
Otis
Peru
Pittsfield
Richmond
Sandisfield
Savoy
Sheffield
Stockbridge
Tyringham
Washington
West Stockbridge
Williamstown
Windsor

REGION I (CONT.)

Westfield Council for Children

27 Washington Street, Westfield, MA 01085

Child Advocate (413) 568-3341
Community Representative (413) 562-5013

Agawam
Blandford
Chester
Granville
Huntington
Montgomery
Russell
Southwick
Tolland
Westfield
West Springfield

Central Pioneer Valley Council for Children

276 High Street, Holyoke, MA 01040

Child Advocate (413) 538-9033
Community Representative (413) 538-9034

Belchertown
Chicopee
Granby
Holyoke
Ludlow
Monson
Palmer
Southampton
South Hadley
Ware

Springfield Council for Children

1694 Main Street, Springfield, MA 01103

Child Advocate (413) 736-0321
Community Representative (413) 736-0321

East Longmeadow
Hampden
Longmeadow
Springfield
Wilbraham

Franklin Council for Children

238 Main Street, Greenfield, MA 01301

Child Advocate (413) 774-7230
Community Representative (413) 774-7239

Ashfield
Athol
Bernardston
Buckland
Charlemont
Colrain
Conway
Deerfield
Erving
Gill
Greenfield
Hawley
Heath
Leverett
Leyden
Monroe
Montague
New Salem
Northfield
Orange
Petersham
Rowe
Roylston
Shelburne
Shutesbury
Sunderland
Phillipston
Warwick
Wendell
Whately

REGION II

75A Grove Street
Worcester, MA 01605
(617) 727-8773

Greater Worcester Council for Children
75A Grove Street, Worcester, MA 01605

Child Advocate (617) 791-9196
Community Representative (617) 727-8773

Auburn
Berlin
Boylston
Holden
Leicester
Paxton
Shrewsbury
West Boylston
Worcester

North Central Council for Children
435 Main Street, Fitchburg, MA 01420

Child Advocate (617) 534-0280
Community Representative (617) 342-8769

Ashby
Ayer
Bolton
Clinton
Fitchburg
Groton
Harvard
Lancaster
Leominster
Lunenburg
Pepperell
Shirley
Sterling
Townsend

Blackstone Valley Council for Children
1 Union Street, Hopedale, MA 01747

Child Advocate (617) 473-3291
Community Representative (617) 473-3291

Bellingham
Blackstone
Douglas
Franklin
Grafton
Hopedale
Medway
Mendon
Milford
Millbury
Millville
Northbridge
Sutton
Upton
Uxbridge

REGION II - CONT.

South Central Council for Children
112 Hamilton Street, Southbridge, MA 01550

Child Advocate (617) 765-9175
Community Representative (617) 885-5374

Brimfield
Brookfield
Charlton
Dudley
East Brookfield
Holland
North Brookfield
Oxford
Southbridge
Spencer
Sturbridge
Wales
Warren
Webster
West Brookfield

……

Wachusett Council for Children
66 Parker Street, Gardner, MA 01440

Child Advocate (617) 632-9179
Community Representative (617) 632-9179

Ashburnham
Barre
Gardner
Hardwick
Hubbardston
New Braintree
Oakham
Princeton
Rutland
Templeton
Westminster
Winchendon

REGION III

83 Pine Street
W. Peabody, MA 01960
(617) 727-8787

Tri-City Council for Children
132 School Street, Everett, MA 01249

Child Advocate (617) 389-5075
Community Representative (617) 389-5424

Everett
Malden
Medford

……

REGION III - CONT.

Haverhill-Newburyport Council for Children

69 Summer Street, Haverhill, MA 01830

Child Advocate (617) 346-9617
Community Representative (617) 372-0161

Amesbury
Boxford
Georgetown
Groveland
Haverhill
Newbury
Newburyport
Rowley
Salisbury
West Newbury

Eastern Middlesex Council for Children

7 Lincoln Street, Wakefield, MA 01880

Child Advocate (617) 245-7430
Community Representative (617) 245-5267

Melrose
North Reading
Reading
Stoneham
Wakefield

Greater Lynn Council for Children

25 Exchange Street, Lynn, MA 01901

Child Advocate (617) 581-7677
Community Representative (617) 581-7683

Lynn
Lynnfield
Nahant
Saugus
Swampscott

Greater Lawrence Council for Children

11 Lawrence Street, Suite 715, Lawrence, MA 01840

Child Advocate (617) 685-0262, 685-0294
Community Representative (617) 688-0262

Andover
Lawrence
Methuen
North Andover

REGION III (CONT.)

Cape Ann Council for Children
100 Powers Street, Beverly, MA 01915

Child Advocate (617) 927-5446
Community Representative (617) 927-3809

Beverly
Essex
Gloucester
Hamilton
Ipswich
Manchester
Rockport
Topsfield
Wenham

……

Heritage Council for Children
57 Conant Street, Danvers, MA 01923

Child Advocate (617) 777-7075
Community Representative (617) 745-9090

Danvers
Marblehead
Middleton
Peabody
Salem

……

Greater Lowell Council for Children
144 Merrimack Street, Rm. 401, Lowell, MA 01852

Child Advocate (617) 459-2566
Community Representative (617) 459-2566

Billerica
Chelmsford
Dracut
Dunstable
Lowell
Tewksbury
Tyngsboro
Westford

REGION IV

1250 Main Street
Waltham, MA 02154

(617) 727-2532
(617) 893-5806

Concord/Assabet Council for Children
75 Great Road, Acton, MA 01720

Child Advocate (617) 264-0314
Community Representative (617) 264-0315

Acton
Bedford
Boxborough
Carlisle
Concord
Lincoln
Littleton
Maynard
Stow

REGION IV (CONT.)

Waltham-Belmont-Watertown Council for Children
283A Belmont Street, Belmont, MA 02178

Child Advocate (617) 891-8558
Community Representative (617) 489-5030

Belmont
Waltham
Watertown

....

Mystic Valley Council for Children
c/o First Congregational Church
21 Church Street, Winchester, MA 01890

Child Advocate (617) 729-4350
Community Representative (617) 729-4350

Arlington
Burlington
Lexington
Wilmington
Winchester
Woburn

....

Somerville/Cambridge Council for Children
1 Summer Street, Somerville, MA 02143

Child Advocate (617) 623-5096
Community Representative (617) 623-5096

Somerville
Cambridge

....

Greater Marlboro Council for Children
223 Pleasant Street, Marlboro, MA 01752

Child Advocate (617) 481-3476
Community Representative (617) 481-3476

Hudson
Marlboro
Northboro
Southboro
Westboro

....

REGION IV (CONT.)

South Middlesex Council for Children
125 Irving Street, Framingham, MA 01701

Child Advocate (617) 875-5264
Community Representative (617) 875-5264

Ashland
Dover
Framingham
Holliston
Hopkinton
Natick
Sherborn
Sudbury
Wayland

……

South Shore Council for Children
49 Hayward Street, E. Braintree, MA 02184

Child Advocate (617) 849-1882
Community Representative (617) 849-1882

Milton
Quincy
Randolph

……

Coastline Council for Children
49 Hayward Street, E. Braintree, MA 02184

Child Advocate (617) 849-1882
Community Representative (617) 849-1882

Braintree
Cohasset
Hingham
Hull
Norwell
Scituate
Weymouth

……

West Suburban Council for Children
474 Centre Street, Newton, MA 02158

Child Advocate (617) 965-9810
Community Representative (617) 965-9810

Needham
Newton
Wellesley
Weston

……

REGION 1V - (CONT.)

South Norfolk Council for Children
896 Main Street, Walpole, MA 02081

Child Advocate (617) 668-7262
Community Representative (617) 668-7262

Canton
Dedham
Foxboro
Medfield
Millis
Norfolk
Norwood
Plainville
Sharon
Walpole
Westwood
Wrentham

REGION V

Lakeville Hospital
Lakeville, MA 02346
(617) 727-1440
(617) 947-1231

Attleboro Council for Children
7 North Main Street, Attleboro, MA 02703

Child Advocate (617) 226-2336
Community Representative (617) 727-8948

Attleboro
Mansfield
North Attleboro
Norton

……

Brockton Council for Children
47 High Street, Brockton, MA 02401

Child Advocate (617) 727-8363
Community Representative (617) 727-8363

Abington
Avon
Bridgewater
Brockton
East Bridgewater
Easton
Holbrook
Rockland
Stoughton
West Bridgewater
Whitman

……

REGION V - (CONT.)

Taunton Council for Children
18 Broadway, Rm. 12, Taunton, MA 02780

Child Advocate (617) 823-7200
Community Representative (617) 727-0886

Berkley
Dighton
Lakeville
Middleboro
Raynham
Rehoboth
Seekonk
Taunton

New Bedford Council for Children
488 Pleasant Street, New Bedford, MA 02740

Child Advocate (617) 727-8974
Community Representative (617) 727-8974

Acushnet
Dartmouth
Fairhaven
Gosnold
Marion
Mattapoisett
New Bedford
Rochester
Wareham

Fall River Council for Children
101 Rock Street, Fall River, MA 02720

Child Advocate (617) 675-0588
Community Representative (617) 675-0589

Fall River
Freetown
Somerset
Swansea
Westport

Cape and The Islands Council for Children
298 Main Street, Hyannis, MA 02601

Child Advocate (617) 727-7723
Community Representative (617) 771-2151

Barnstable
Bourne
Brewster
Chatham
Chilmark
Dennis
Eastham
Edgartown
Falmouth
Gay Head
Harwich
Mashpee
Nantucket
Oak Bluffs
Orleans
Provincetown
Sandwich
Tisbury
Truro
Wellfleet
West Tisbury
Yarmouth

REGION V (CONT.)

Plymouth Council for Children
130 Court Street, Plymouth, MA 02360

Child Advocate (617) 727-8945
Community Representative (617) 746-5101

Carver
Duxbury
Halifax
Hanover
Hanson
Kingston
Marshfield
Pembroke
Plymouth
Plympton

REGION VI

150 Causeway Street, Room 806,
Boston, MA 02114
(617) 727-8898

Boston-Southern Council for Children
1665 Blue Hill Avenue, Mattapan, MA 02126

Child Advocate (617) 296-2070
Community Representative (617) 296-2070

Hyde Park
Mattapan
Roslindale
South Dorchester
West Roxbury

……

Inner City Council for Children
90 Warren Street, Roxbury, MA 02119

Child Advocate (617) 427-0606
Community Representative (617) 427-0606

Back Bay
Roxbury
South End

……

Capitol Council for Children
68 Central Square, East Boston, MA 02128

Child Advocate (617) 567-1950
Community Representative (617) 567-1950

Beacon Hill
Charlestown
East Boston
North End

……

REGION VI (CONT.)

Chelsea-Revere-Winthrop Council for Children
5-11 Everett Street, Chelsea, MA 02150

Child Advocate (617) 889-4954
Community Representative (617) 889-4954

Chelsea
Revere
Winthrop

……

Bos-Line Council for Children
824 Huntington Avenue, Boston, MA 02115

Child Advocate (617) 738-4518
Community Representative (617) 738-4518

Allston
Brighton
Brookline
Fenway
Jamaica Plain
Mission Hill

……

Bayside Council for Children
52-54 Victory Road, Dorchester, MA 02122

Child Advocate (617) 288-6600
Community Representative (617) 288-6600

Chinatown
Columbia Point
Dorchester
South Boston

Appendix 22
Child Care Resource and Referral Programs

AS OF JANUARY, 1988

PROGRAM NAME	*OFC AREAS SERVED*
RESOURCES FOR CHILD CARE 311 North Street Pittsfield, MA 01201 (413) 499-7982 (Parent Calls) (413) 499-7983 (Administration)	Berkshire County
CHILD CARE FOCUS 55 Federal Street Greenfield, MA 01301 (413) 773-7519; 1-800-322-0270	Franklin County
56 Vernon Street P.O. Box 7 Northampton, MA 01060 (413) 586-4940; 1-800-962-5511	Hampshire County
PRESCHOOL ENRICHMENT TEAM 276 High Street Holyoke, MA 01040 (413) 536-3900	Hampden County Greater Springfield Westfield Central Pioneer Valley (partial)
CHILD CARE RESOURCES 435 Main Street - Box 7341 Fitchburg, MA 01420 (617) 343-7395 (Fitchburg) (617) 365-6367 (Clinton) (617) 630-1269 (Gardner)	Wachusett North Central
CHILD CARE CONNECTION 484 Main Street Worcester, MA 01608	Greater Worcester
100 Main Street Whitinsville, MA 01588 (617) 755-1233 (Parent Calls) (617) 757-5631 (Administration)	Blackstone Valley South Central
CHILD CARE CIRCUIT 190 Hampshire Street Lawrence, MA 01840 (617) 686-4288	Lawrence North Essex
88 Broad Street Lynn, MA 01902 (617) 592-8440	Lynn Heritage Cape Ann
388 Pleasant Street Malden, MA 02148 (617) 324-1262; 324-3887	Tri-City Eastern Middlesex

CHILD CARE SEARCH 60 Turner Street Waltham, MA 02154 (617) 891-4557	Waltham Concord-Assabet Mystic Valley
11 Kearny Square Lowell, MA 01852 (617) 452-6445	Greater Lowell
P.O. Box 568 276 Union Avenue Framingham, MA 01701 (617) 875-9883	South Middlesex Greater Marlboro
CHILD CARE RESOURCE CENTER 552 Massachusetts Avenue Cambridge, MA 02139 (617) 547-9861 (Parent Calls) (617) 547-1063 (Administration)	Cambridge/Somerville West Suburban Belmont/Watertown
1485 Dorchester Avenue Dorchester, MA 02122 (617) 547-9861 (Parent Calls) (617) 547-1063 (Administration)	Boston Chelsea Revere Winthrop
COMMUNITY CARE FOR KIDS 1509 Hancock Street Quincy, MA 02169 (617) 479-8181	South Shore Coastline
Plymouth Industrial Park, P.O. Box 6067 Plymouth, MA 02360 1-800-637-2011; 746-5180, X46 and 47	Plymouth
CHILD CARE RESOURCE EXCHANGE 4 Park Place New Bedford, MA 02742 (617) 999-9930; 1-800-338-1717	Greater New Bedford
77 High School Road Extension Hyannis, MA 02601 (617) 771-0141; 1-800-352-3153	Cape & Islands
CHILD CARE RESOURCE CONNECTION 17 Tremont Street Taunton, MA 02780 (617) 823-9118 (Taunton); (617) 675-9283 (Fall River)	Fall River Taunton
HOME/HEALTH & CHILD CARE SERVICES 15A Bolton Place Brockton, MA 02401 (617) 588-6070 (Brockton); 1-800-222-5609	Brockton South Norfolk Attleboro

Appendix 23
Resource Guide on Child Sexual Abuse

Listed below are resources such as prevention programs, organizations, service providers and bibliographies. This guide is not meant to be comprehensive but to highlight some programs and resources available in Massachusetts.

Within the Division of Family Health Services, you can contact:

Coordinator
Resource Center for the Prevention of Family Violence and Sexual Abuse
Division of Family Health Services
Massachusetts Department of Public Health
150 Tremont Street
Boston, MA 02111
(617) 727-7222

The Resource Center houses films, books, and pamphlets about child sexual abuse. These materials are available for loan. In addition, referral to local services and presentation programs is available.

PREVENTION PROGRAMS

MASS/CAPP

MASS/CAPP trains 30 volunteers at a time to implement Child Assault Prevention Programs (CAPP) in their own communities. It is a three-day (eighteen-hour) program. CAPP has three components: Teacher In-Service, Parent Program, and Children's Workshop. Presentations include "Understanding Child Sexual Assault," "The Why and How of Prevention," "Getting Started" (school and agency negotiation, strategies for fund raising), "The Worker as Child Advocate," "Working in Culturally Diverse Communities," "Classroom Philosophy," and "Adult and Classroom Workshops." MASS/CAPP is available to most of the state. Contact:

MASS/CAPP
Judge Baker Children's Center
295 Longwood Avenue
Boston, MA 02115
(617) 232-8390 x2608

OTHER PROGRAMS

Worcester County (DSS Region 2), Fitchburg/Gardner Area, has a Personal Safety Curriculum available developed by Geraldine Crisci. This is a graduated curriculum building on concepts from preschool through grade six. Many different curriculum activities are available, which are appropriate for a number of different formats. For more information, contact:

ACCESS Program
Herbert Lipton Mental Health Center
Fitchburg, MA
(617) 537-6039

or

Personal Safety Program
P.O. Box 763
Hadley, MA 01035

SERVICE PROVIDER

Children's Hospital Sexual Abuse Treatment Team
300 Longwood Avenue
Boston, MA 02115
(617) 735-6940

Appendix 24

Selected Resources for Health in Day Care

This appendix presents some samples of the most helpful health materials for day care available at this time. In some cases, other detailed lists may be requested from the organizations listed. The Preschool Health Program has available extensive bibliographies on many health-related topics, including materials for teaching children about health. The Preschool Health Program will continue to collect resources after publication of this Guide. If you would like additional references or up-to-date suggestions, please contact the:

Preschool Health Program
Massachusetts Department of Public Health
Division of Family Health Services
150 Tremont St., 3rd Floor
Boston, MA 02111
(617) 727-0944

HEALTH IN DAY CARE REFERENCES & TRAINING GUIDES FOR PROVIDERS

American Red Cross of Massachusetts Bay, Health and Safety for Infants and Children, 1986. (99 Brookline Ave., Brookline, MA 02115.)

Anderson, R., Bale, J., Brackman, J., Murphy, J., Infections in Children: A Sourcebook for Educators & Child Care Providers, 1986. Rockville, MD: Aspen Publishers.

Bananas Child Care Information and Referral and Parent Support, Sick Child Care Guide for Parents and Child Care Providers, 1980. (6501 Telegraph Ave., Oakland, CA 94609.)

California SIDS Program, Sudden Infant Death Syndrome - What Child Care Providers and Other Caregivers Should Know. (2151 Berkeley Way, Annex 4 Room 400, Berkeley, CA 94704.)

Centers for Disease Control, What You Can Do To Stop Disease in the Child Day Care Center, (Stock #017-023-00172-8), 1984. U.S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402.

Child Care Employee Project, Health and Safety Resources for Child Care Workers, 1984. (P.O. Box 5603, Berkeley, CA 94705.)

Child Care Resource and Referral, Inc., Health and Safety--A First Aid, Safety, and Medical Information Guide, 1984. (903 W. Center St., Suite 200, Rochester, NY 55902.)

Georgetown University Child Development Center, Health in Day Care: A Training Guide for Day Care Providers, 1986. (3800 Reservoir Road, N.W. Washington, D.C. 20007.)

This training guide was developed as a companion manual based on Health in Day Care. It details workshop formats to train child care providers on the material from this manual. It will be most useful to you in actually applying the information to training in your site.

Greater Minneapolis Day Care Association, Child Health Guidelines: Health, Nutrition, Infants, and Toddlers, 1985. (1006 West Lake, Minneapolis, MN 55408.)

Health Professionals in Child Care, InSight Productions, Healthy Child Care, Is It Really Magic?, 1988. Video Training Program. (745 Page St., Berkeley, CA 94710.)

National Association for the Education of Young Children, Accreditation Criteria and Procedures of the National Academy of Early Childhood Programs, 1984. (1834 Connecticut Ave., Washington, D.C. 20009.)

Project Care for Children, Child Emergency and Medical Guidelines for Child Care Providers and Parents, 1986. Handy flipbook format. (828 Mission Ave., San Rafael, CA 94901, 415-454-7957.)

Resources for Child Caring, Inc., Health, Safety, and First Aid: A Guide for Training Child Care Workers, Toys 'n Things Press, 1980. (906 North Dale, St. Paul, MN 55103.)

Seattle - King County Department of Health, Child Day Care Health Handbook, Day Care Health Program, 1985. (Room 1406, Public Safety Building, Third and James, Seattle, WA 98104.)

Stetler, R., Don't Sneeze at Disease, 1987, Resources for Family Development. (1520 Catalina Court, Livermore, CA 94550.)

RESOURCES FOR HEALTH CONSULTANTS AND POLICY MAKERS

American Academy of Pediatrics, Committee on Infectious Diseases, Report of the Committee on Infectious Diseases, (AAP "Red Book"), 20th Edition, 1986. (P.O. Box 927, Elk Grove Village, IL 60009.)

American Academy of Pediatrics, Health in Day Care: A Manual for Health Professionals, 1987. (P.O. Box 927, Elk Grove Village, IL 60009.)

Benenson, A., Control of Communicable Diseases in Man, 1985, Washington, D.C.: American Public Health Association.

Department of Health, Education and Welfare, Health Services: A Guide for Head Start Project Directors and Health Personnel, 1972, DHEW Publication No. OHDS 78-31060. U.S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402.

Gunzenhauser, N. and Caldwell, B., (Eds.), Group Care for Young Children: Considerations for Child Care Workers and Health Professionals, Public Policy makers, and Parents, 1986, Johnson and Johnson Baby Products Company, Pediatric Roundtable Series, #12.

Haskins, R. and Kotch, J., Day Care and Illness: Evidence, Cost, and Public Policy, Pediatrics, 77, Supplement, June 1986, part 2.

Kansas Department of Health and Environment, Health of Children in Day Care: Public Health Profiles, 1986.

Osterholm, M., Klein, J., Aronson, S., and Pickering, L., Infectious Diseases in Child Day Care: Management and Prevention, Review of Infectious Diseases, 8:4, July-Aug 1986. In book form: University of Chicago Press, Journal Division. (P.O. Box 37005, Chicago, IL 60637.)

Ross Laboratories, Report of the Sixteenth Ross Roundtable, Day Care, 1985, Columbus, OH 43216.

Sleator, E., Infectious Diseases in Day Care, ERIC Clearinghouse, 1986. University of Illinois. (805 West Pennsylvania Ave., Urbana, IL 61801.)

CHILD HEALTH

American Medical Association, Children: How to Understand Their Symptoms, 1986, New York: Random House.

Boston Children's Medical Center and Feinbloom, R., Child Health Encyclopedia: The Complete Guide for Parents, 1975, New York: Delacorte Press/Seymour Lawrence.

Marotz, L., Rush, J., and Cross, M., Health, Safety, and Nutrition for the Young Child, 1985, Department of Human Development and Family Life, University of Kansas. Delmar Publishers, Inc. (2 Computer Dr. W., Box 15-015, Albany, NY 12212.)

Pantell, R.H., Fries, J.F., and Vickery, D.M., Taking Care of Your Children, 1984, Reading, MA: Addison-Wesley.

Reinisch, E.H. and Minear, R.E., Jr., Health of the Preschool Child, 1978, New York: John Wiley & Sons.

CHILDREN WITH SPECIAL NEEDS

Black, E. and Nagel, D., Eds., Physically Handicapped Children: A Medical Atlas for Teachers, 1982, 2nd Ed., New York: Grune and Stratton.

Booth, A., Donebad, P., and Maykut, P., Mainstreaming Children with a Handicap in Day Care and Preschool: A Manual of Training Activities, 1981, Madison, WI: Wisconsin Council on Developmental Disabilities.

Department of Health, Education, and Welfare, Day Care Series #8: Serving Children with Special Needs, 1972. Stock #1791-0176, Superintendent of Documents, U.S. Printing Office, Washington, D.C. 20402.

Froschl, M., Colon, L., Rubin, E., and Sprung, B., Including All of Us: An Early Childhood Curriculum about Disability, 1984, Educational Equity Concepts, Inc. (Distributed by Gryphon House, Inc., P.O. Box 275, Mt. Rainer, MD 02712.)

Texas Department of Human Resources, Caring for Handicapped Children, Development Materials, Child Development Program, Texas Department of Human Resources. (P.O. Box 2960, Austin, TX 78769.)

The Regional Educational Centers in Massachusetts (see Appendix 10) have a number of resources related to children with special needs available for loan. The following may be borrowed by contacting the Center in your area:

Kids on the Block
A set of puppets with disabilities. The puppets come with a teacher's guide, scripts, information about each disability, and resource ideas for additional activities and materials.

Mainstreaming Through the Media
A bibliography/guide of books and materials aimed at helping young children understand and accept differences among people. The guide is furnished free. The kit is available at each Center for inspection.

Special Friends
A set of unique fabric toy animals representing varied special needs. Excellent for understanding through dramatic play.

Young and Special Videotapes
A series of videotapes which are excellent for staff training. The complete course of 30 modules introduces all special needs and levels of severity and integrates modules on normal development. They are very effective used individually or in a series.

U.S. Dept. of HHS/Office of Human Development Services, Mainstreaming Preschoolers, 1978, Superintendent of Documents, U.S. Printing Office, Washington, D.C. 20402.

Children with Orthopedic Handicaps, Stock #017-092-00034-1.
Children with Visual Handicaps, Stock #017-092-00030-8.
Children with Mental Retardation, Stock #017-092-00029-4.
Children with Health Impairments, Stock #017-092-00031-6.
Children with Hearing Impairments, Stock #017-092-00032-4.
Children with Emotional Disturbance, Stock #017-092-00036-7.
Children with Speech and Language Impairments, Stock #017-092-00033-2.
Children with Learning Disabilities, Stock #017-092-00035-9.

HEALTH CURRICULA FOR CHILDREN

Administration for Children, Youth, and Families, Head Start Dental Health Curriculum, 1985. DHHS Publication #(OHDS) 86-31535, Superintendent of Documents, Washington, D.C.

American Heart Association, Heart Treasure Chest. (See Organizations listing.)

American Lung Association of Los Angeles County, Safe at Home, (5858 Wilshire Blvd, Los Angeles, CA 90036, 213-935-LUNG.)

Brevis Corporation. Germ-Glo and other very clever and appealing materials on handwashing for children and adults. (3310 South 2700 East, Salt Lake City, UT 84105, 800-826-2427.)

Freeman, Lory, What Would You Do If..., A Kid's Guide to First Aid, 1983, Parenting Press. Emphasizes discussion of prevention and first aid information for children. (7750 31st Ave., NE, Seattle, WA 98115.)

Health and Safety for Young Children, Child Involvement in Personal Health, 1974, Macmillan Publishing Company, Inc., Threshold Division. (866 Third Ave., New York, NY 10022.)

Hendricks, C. and Smith, C.J., Hale and Hardy Helpful Health Hints: A Comprehensive Health Education Curriculum for Head Start Programs, 1982, Bowling-Green, KY: Barren River District Health Department.

Kerr, A., Health, Safety, and Nutrition Early Childhood Curriculum, 1985, Lakeshore Curriculum Materials Company. (295 E. Dominguez St, Carson, CA 90749.)

Miller, J. Web of Life: Health Education Activities for Children, 1975. (Can be ordered from Pennsylvania Department of Education, Bureau of Curriculum and Instruction, 8th Fl., 333 Market Street, P.O. Box 911, Harrisburg, PA 17108.)

National Dairy Council, Chef Combo. (Nutrition curriculum kit including puppets, games, activities, etc.; see Organizations listing for N.E. Dairy Council.)

Peterson, P., Ready...Set...Grow!!, A Comprehensive Health Education Curriculum for 3-5 Years Olds, 1984. Peterson Publishing. (P.O. Box 75991, St. Paul, MN 55175.)

Schultz, T. and Sorenson, L., Organic Puppet Theater, Children's Activities in Health Awareness, 1983, NightOwl Press. (1537 West Iowa Ave., Minneapolis, MN 55415.)

SCIPP, SAFE DAYCARE, 1986. Kit for providers with teacher's guide curricula, safety checklists, handouts, and resources. (See Safety/First Aid Section of this Appendix).

Scrubby Bear Foundation, Materials and resources on handwashing for children and adults. (1155 15th St, NW., Suite 500, Washington, D.C., 202-728-1063.)

Sheehan, M. and Newell, P., I'm So Glad You Asked, 1987. Preschool curriculum on alcohol and other substances in the home. Relevant for children from alcoholic and other dysfunctional families. (I'm So Glad You Asked, Inc., P.O. Box 329, Amherst, MA 01004, 413-549-3873.)

Upjohn Company, "First Things First - Your First Book About First Aid" (for children). (Upjohn First Things First, 3rd Fl., 99 Park Avenue, New York, NY 10016.)

Whicker, P., Aim for Health, 1983, Winston-Salem, NC: Kaplan Press.

NUTRITION

Bershad, C. and Bernick, D., Bodyworks: The Kid's Guide to Food and Physical Fitness, 1981, New York: Random House.

Brody, J., Jane Brody's Nutrition Book, 1981, New York: W.W. Norton and Company.

Goodwin, M.T. and Pollen, G., Creative Food Experiences for Children, 1980, Washington, D.C.: Center for Service in the Public Interest.

Massachusetts Department of Public Health, Infant Feeding Policy, June 1984.

Natow, A. and Heslin, J.A., No-Nonsense Nutrition for Kids, 1984, New York: McGraw-Hill.

Satter, F., Child of Mine - Feeding with Love and Good Sense, 1983, Bull Publishing Company.

U.S. Department of Agriculture, Food and Nutrition Service, A Planning Guide for Food Service in Child Care Centers, 1985, FHS-64, Washington, D.C., Government Printing Office.

U.S. Department of Agriculture and U.S. Department of Health and Human Services, Nutrition and Your Health: Dietary Guidelines for Americans, 1985, 2nd Edition, Home and Garden Bulletin No. 232, Washington, D.C., Government Printing Office.

Vonde, D. and Beck, J., Food Adventures for Children, 1980, Redondo Beach, CA: Plycon Press.

Winick, M., Growing Up Healthy: A Parent's Guide to Good Nutrition, 1981, New York: William Morrow & Company.

Zeitlin, M., Connell, D., Schlossman, N., Rall, V., and Ryden, T., Breastfed Babies: Guidelines for the Day Care Provider, 1986, Weston, MA: Lactation Associates.

SAFETY AND FIRST AID

Safety

SCIPP (Statewide Comprehensive Injury Prevention Program), Massachusetts Department of Public Health, 150 Tremont Street, Boston, MA 02111. (Has developed hands-on instructional kits for injury prevention: SAFE DAYCARE, SAFESCHOOL, SAFECHILD, SAFEHOME. Excellent materials and handouts. Resource library with written and audiovisual materials for loan.) 617-727-1246.

Comprehensive Loss Management, Inc., Safe Care, Video Training Program. Fifteen minute video and four training manuals for assessing the environment in centers. (6601 Shingle Creek Pkwy, Suite 800, Minneapolis, MN 55430.)

First Aid

American Red Cross of Massachusetts Bay, Health and Safety for Infants and Children, 1986. (99 Brookline Ave., Brookline, MA 02115.)

Green, Martin, A Sigh of Relief - The First Aid Handbook for Childhood Emergencies, 2nd Ed., Bantam, NY.

Williams, Kenneth, Childhood Emergency Sourcebook, in collaboration with the Preschool Enrichment Team, Inc., 1985. (P.E.T., 276 High Street, Holyoke, MA 01040.)

Also see Health in Day Care References & Training Guides for Providers and Health Curricula for Children sections.

SICK CHILD CARE

Fredericks, B., Hardman, R., Morgan, G., Rodgers F., A Little Bit Under the Weather, 1986, Work/Family Directions, Inc. (9 Galen St., Suite 230, Watertown, MA 02172.)

Mohlabane, Noa, Infants in Day Care Centers--In Sickness and in Health, 1984, BANANAS Child Care Information and Referral Service. (6501 Telegraph Ave., Oakland, CA 94609.)

Parents in the Workplace, Sick Child Care: A Problem for Working Parents and Employers, 1983, Greater Minneapolis Day Care Association. (1006 W. Lake St., Minneapolis, MN 55408.)

VISION SCREENING

1. Preschool Vision Screening Package
   available from: The Preschool Enrichment Team, Inc.
   276 High Street
   Holyoke, MA 01040

2. Snellen E (Tumbling E)
   available from: National Society for the Prevention of Blindness
   79 Madison Avenue
   New York, NY 10016

3. Broken Wheel Test
   available from: Burnell Corporation
   750 Lincolnway East
   P.O. Box 4637
   South Bend, IN 46634

Preschool Vision Screening Package includes:

Preschool Vision: Step by Step

This is a step by step manual for setting up a quality vision screening program for children 3-6 years old. Includes detailed directions for screening children, applying criteria for passing or failing screening, and steps in making a referral for further vision evaluation. Appendices include screening materials, examples of letters to parents and doctors, scoring forms, and resource list. The Broken Wheel Test is included.

"Preschool Vision Screening: A Reason to Start Young"

An education pamphlet for professionals working with young children. It includes the relationship of vision to learning, basic facts about formal and informal classroom screening, what educators can do to encourage healthy vision and information about vision and television. Appendices include bibliography, glossary, resource list and descriptions of other P.E.T. vision materials.

"Vision and Your Preschooler"

A one page pamphlet for parents which provides information about vision, vision screening, what parents can watch for, information about eye care specialists and treatment, and what parents can do to encourage healthy vision.

SELECTED ORGANIZATIONS AND CLEARINGHOUSES

American Academy of Pediatrics, P.O. Box 927, Elk Grove Village, IL 60007. 800-433-9016. (Excellent educational materials. Publication list available.)

American Dental Association, 211 East Chicago Ave., Chicago, IL 60611. (Has resources and educational materials for dental health.)

American Heart Association, Massachusetts Affiliate, Inc., 33 Fourth Ave., Needham Heights, MA 02194. 617-449-5931. Also has affiliate offices in Pittsfield, Hyannis, Auburn, Andover, Brockton, and Springfield. (Has materials, resources, and training related to heart health including nutrition, exercise, CPR certification, etc. See Figure 1 for the Heart Treasure Chest.)

American Public Health Association, 1015 Fifteenth St. N.W., Washington, D.C. 20005. 202-789-5600. (Has journal and publication list.)

American Red Cross, Greater Boston Chapter, 99 Brookline Ave., Boston, MA 02215. 617-262-1234. Also major chapters in Worcester, Springfield, and Pittsfield. (Offers resources and courses in first aid, babysitting, parenting, nutrition, and CPR certification.)

Association for the Care of Children's Health, 3615 Wisconsin Ave., N.W., Washington, D.C. 20016. 202-244-1801. (Has journal and publications about hospitalization and psycho-social aspects of illness.)

Centers for Disease Control, Center for Infectious Diseases, Division of Viral Diseases, Public Health Services, 1600 Clifton Road., N.E., Atlanta, GA 30333. 404-329-3091.

Child Care Employee Project, P.O. Box 5603, Berkeley, CA 94705. 415-653-9889. (Has information related to child care working conditions and improving the status of child care workers.)

Child Care Health Project, 8374 Fresno Ave., La Mesa, CA 92041, 619-697-9002. (A clearinghouse and resource service on health and safety issues in child care. Educational materials available.)

Children's Defense Fund, 122 C St. N.W., Washington, D.C. 20001. 202-628-8787. (Active advocacy organization for children and family rights. Has newsletter, "CDF Reports." Has state affiliates.)

Consumer Product Safety Commission, 31 St. James Street, Boston, MA 02116. 617-223-5447; 1-800-638-CPSC - Hotline.

Council for Exceptional Children, Information Services, 1920 Association Drive, Reston, VA 22091. (Has journal and resources related to children with disabilities.)

ERIC/EECE, Educational Resources Information Center, Elementary and Early Childhood Education, University of Illinois, 805 W. Pennsylvania Ave., Urbana, IL 61801. 217-333-1386. (Collections of all types of written information. Free resources, a newsletter, and "ready search" of topics, including health and safety.)

Federation for Children with Special Needs, 312 Stuart St. 2nd floor, Boston, MA 02116. 617-482-2915. (Excellent resource organization for information and assistance related to children with special needs.)

Head Start Health Services, Administration of Children, Youth, and Families P.O. Box 1182, Washington, D.C. 20013. 202-755-7794. (Has performance standards for health, nutrition, dental, and mental health. Child curricula for nutrition and dental health.)

Mass. Poison Information Center, Children's Hospital, 300 Longwood Ave., Boston, MA. 232-2120 - Emergency (Boston), 1-800-682-9211 - Emergency (Massachusetts).

National Association for the Education of Young Children, 1834 Connecticut Ave. N.W., Washington, D.C. 20009. 800-424-2460. (Has statewide and area affiliates in Massachusetts. Provides conferences and workshops, monthly professional journal. Child Care Information Service provides computer searches and toll-free hotline for quick facts and referrals. Accreditation standards include health and safety.)

National Center for Education in Maternal and Child Health, 3520 Prospect St. N.W., Washington, D.C. 20057. 202-625-8400. (Has resource lists of publications and organizations on many health topics.)

National Fire Protection Association, Battery March Park, Quincy, MA 00269. 617-328-9230.

National Health Information Clearinghouse, P.O. Box 1133, Washington, D.C. 20013-1133. 800-336-4797. (Has information resources and referral system.)

National Safety Council, 444 North Michigan Avenue, Chigago, IL 60611, 1-800-621-7619; Massachusetts Safety Council, 111 Beach Street, 2nd Floor, Boston, MA 02111-2511, 617-542-6067; Central Massachusetts Chapter, 25 Quinsigamond Avenue, Worcester, MA 01608, 617-791-9366; Western Massachusetts Chapter, 90 Berkshire Avenue, Springfield, MA 01109, 413-737-7908. (Has excellent written and audio-visual resource materials on all aspects of safety.)

New England Dairy Council, 1034 Commonwealth Ave., Boston, MA 02215. 617-734-6750. Also has offices in Worcester and West Springfield. (Offers nutrition and health promotion materials and workshops. "Chef Combo" curriculum kit available for purchase.)

PERIODICALS

Child Care Information Exchange, P.O. Box 2890, Richmond, WA 98073. (Monthly magazine for directors with regular health update column written by Dr. Susan Aronson. Articles are extremely informative and well-written about important child care issues.)

Child Care News, Child Care Resource Center, 552 Massachusetts Ave., Cambridge, MA 02139. 617-547-1063. (Ten newsletters per year with excellent coverage of child care issues, including alternating column on health.)

Child Health Alert, P.O. Box 338, Newton Highlands, MA 02161. (A monthly newsletter with summaries and comments on recent health research and issues. Written in clear and understandable format. Excellent resource).

Parents Pediatric Report, P.O. Box 155, Providence, R.I. 02906. (Excellent newsletter eleven times per year.)

Pediatrics for Parents, 176 Mt. Hope Ave., Bangor, ME 04401, 207-942-6212. (Excellent monthly newsletter with practical health information in easy-to-read format. Summaries of research and helpful hints dealing with children. Appropriate for parents and staff).

Please refer to the list of organizations for other publications. Contact your local Child Care Resource and Referral Agency for other local resources.

SECTION IX
INDEX

Acoustic reflex (hearing screening), 137
Adult health, 143-150
  environment, 144
  infectious diseases, 147-148
  medical exams, 145-146
  TB screening, 325
AIDS/HIV infections, 364-367
  attendance recommendations, 366-367
Air quality, 34-35
Allergies, 239-241
Anemia, 176-177, 249-250
Animals, care of, 44
Art and crafts materials, risks, 70-71
Asbestos, 35-36
Associations for Retarded Citizens (ARC's), 211
Asthma, 241-244

Bee stings, 240
Bleach solution, recommended, 29-30, 42, 261, 262, 358
Blood contact infections, 358-367
  control and prevention, 358
  reporting, 361-362
  types
    AIDS/HIV, 364-367
    Hepatitis B, 359-363
Board of Health, 265-269
Boston Urban Gardeners (BUG), 200
Broken Wheel vision test, 135
Brushing teeth, 153-154

Campylobacter, 291-294
Candida infections, 379
Carriages, 82
Carriers, 81
Car seats and restraints, 93
  laws and standards, 91-92
Chickenpox, 312-314
Child abuse and neglect, 213-228
  complaints, 225-226
  defined, 214-215
  indicators, 216-219
  law, 213
  mandated reporter, 213, 215
  parents, 220-221
  prevention and screening, 226-228
  reporting, 215-225
  Sudden Infant Death Syndrome (SIDS), 226
  See also Special needs, children with
Child at Risk Hotline, 221
Child Care Food Program (CCFP), 195-196
  meal patterns, 188
Child Care Resource and Referral agencies (CCRR's), 211
Childcare workers. *See* Staff
Child development.
  developmental health history form, 127-128
  developmental "red flags", 130
  milestones, 129-131
  observing and recording observations, 126-133
  screening and assessment, 131
Childhood Emergency Sourcebook, 105
Childhood Lead Poisoning Prevention Program (CLPPP), 230, 233
Choking, 66-67
Chronic health conditions, 235-253
  allergies, 239-241
  asthma, 241-244
  diabetes, 250-253
  emergency planning, 253
  epilepsy/seizure disorders, 246-248
  heart problems, 244-246
  sample health record, 237-238
  sickle cell anemia, 249-250
  See also Emergencies; Special needs, children with
Cleaning, 42-43; *See* Sanitation
  food contact surfaces and utensils, 47-48, 192-193
  infectious diseases, 261-262, 274
CMV, 350-351
Colds, 304-306, 390
Community resources, 11, 132-133
  nutrition, 195-200
  special needs, 207-211;
  See also Health care consultants
Confidentiality, 13, 362
Conjunctivitis (pink eye), 335-337
Constipation, 395
Consultants. *See* Health care consultants
Contaminated items, 36-37; *See also* Food preparation and handling

Councils for Children, 210-211
Cribs, 82
Curriculum samples
  "A Healthy Heart," 17-19
  dental health, 24
  mental/social health, 25
Cytomegalovirus (CMV) infection, 350-351

Dehydration, 396
Dental health, 151-158
  brushing teeth, 153-154
  education, 154
  referral criteria and special problems, 156-158
Dentist, 155
Denver Developmental Screening Test (DDST), 131
Department of Mental Health, 209-210
Department of Public Health
  immunization requirements and schedules, 263-264
  reportable diseases, 267-268
Department of Social Services, 210, 213
  reporting child abuse, 220-225
Development. *See* Child development
"Developmental Red Flags," 130
Diabetes, 250-253
Diapering, 53-55
  changing surfaces, 79
  infectious diseases, 261,274
  poisons, 72
  procedure, 56
  See also Sanitation; Toileting
Diaper rash, 379, 394
Diarrhea, 391-392, 272-277; *See* individual intestinal diseases
Diet
  allergies and intolerances, 177-178
  calcium, 173-174
  fats, sugar and salt, 171-172
  guidelines, 182-183
  vegetarian, 172-173
Diphtheria, 374
Direct Contact Diseases
  Generalized infections, 348-357
    control and prevention, 348-349
    sexually transmitted, 355-357
    types
      Cytomegalovirus (CMV), 350-351
      Herpes simplex, 352-354
  Skin and superficial infections, 327-344. *See* Direct Contact Diseases
    control and prevention, 327-328
    sample letters to parents. *See* Letters to parents
    types
      conjunctivitis, 335-337
      impetigo, 329-331
      pediculosis (head lice), 341-347
      ringworm, 332-334
      scabies, 338-340
Dishwashing, 48, 261
District Attorney reporting law, 220
Division of Communicable Disease Control, 10, 258
Drowning, 77

Ear infections, 377-378
Early Intervention Programs, 207
Early Screening Instrument (ESI), 131
Education. *See* Health education
Electrical wiring, 66
Emergencies, 99-116
  assistance, 101-102
  evacuation, 102-105
  first aid, 102, 105-111
  group management, 105
  injury report, 100-101, 109
  poisons, 109-110
  procedures, 100-101, 112
  sample emergency transportation permission form, 113
  sample phone list, 115
  transportation, 92-95
  See also Chronic health conditions
Emergency feeding agencies, 198-199
Environmental concerns, 29-40
  air quality, 34-35
  allergies, 241
  contaminated items, 36-37
  eating and food handling, 36, 164
  handwashing, 30-33
  infectious diseases, 260-262
  lead, 230, 232-233
  play materials and activities, 38-39
  staff health, 144
  use of space, 34, 51
  See also Safety; Sanitation
Epilepsy/seizure disorders, 246-248
Equipment and supplies
  fire emergency, 105

  first aid, 102, 116
  housekeeping, 43
  nursery, 78-84
  storage, 192
  toileting, 50, 58
  transportation, 94-95
Evacuation plans, 102-105
Expanded Food and Nutrition Education Program (EFNEP), 199-200

Failure-to-Thrive, 177
Febrile seizures, 390
Federation for Children with Special Needs, 211
Feeding infants and toddlers, 161-165
  bottle feeding, 161, 191
  cow's milk, 163
  food consumption, 164
  new foods, 170
  nutritional problems, 173-181
  safety, 170-171
  snacks, 166-167
  solid foods, 162-163
  See also Nutrition
Fevers, 387-390
Field trip and carpool safety, 76, 95-96
Fire emergency, 104
First aid, 105-111
  education, 110-111
  injury assessment, 106-109
  kit, 102, 116
Fluoride, 152-153
Food allergies and intolerances, 177-179
Food banks and pantries, 198-199
Food Distribution Program, 196-197
Food groups, 165-166
Food preparation and handling, 36, 186-194
  breast milk and formula, 191
  cleaning, 193-194
  infectious diseases, 269, 287, 291
  menu planning, 186-190
  procedures, 47, 192-194
  purchasing and storage, 190-193
  See also Kitchen facilities; Nutrition
Food Stamp Program, 197

Garbage disposal, 49
Getting emergency help, 101-102
Giardia lamblia, 278-282
Gloves, disposable, 33, 36, 55, 277, 358
Governor's Task Force on AIDS, 364-365
Group management
  emergency, 105
  infectious diseases, 37, 274

Haemophilus influenza type B (Hib disease), 319-322
Handwashing, 30-33, 44-46
  infectious diseases, 147, 261, 274, 327-328
Head lice (pediculosis), 341-347
Head Start programs, 209
Health assessment, 122-125
  See also Health observation; Health screening
Health care consultants, 7-11
  dentist, 155
  early intervention, 207
  mental health, 209-210
  OFC regulation, 8
  pediatrician, 9
  special education, 207-209
  See also community resources
Health curriculum, preschool, 16-17
  curriculum samples, 17-19, 24, 25
  safety, 87, 97
Health education, 15-26
  adult lesson plan, sample, 122-123
  auto safety, 97
  dental, 154
  first aid, 110-111
  integrated, 22
  nutrition, 183-186
  preschool, 16-17
  safety, 86-87
  staff/parent, 20-22, 98
Health histories, 126-128
Health observation, 5-6, 126-132
  child development, 129-132
  physical health, 126-129
  sick child care, 386-387
Health policies, 3-13
Health records, 12-13
  Certificate of Immunization, 265, 266
  chronic illness, 235, 237-238, 243
  histories, 126
  injury report, 100-101, 109, 225
  sample medication form, 399
Health screening, 125, 133-137
  height and weight, 137
  lead levels, 137, 230-231
  hearing, 135-137

  vision, 134-135
  tests and instruments, 131, 135, 136-137
Hearing screening, 135-137
Heart problems, 244-246
Heat exhaustion and dehydration, 396
Help for Children, 211
Hepatitis A, 298-301
Hepatitis B, 359-363
Herpes simplex viral (HSV) infections, 352-354
Hib disease, 319-322
High chairs, 80
High-risk infant community-based support programs, 207
Housekeeping, 42-44
Hunger Hotline, 198
Hygiene. *See* Sanitation
Hyperactivity, 179

Immunization, 147-148, 262-266
  Hepatitis B, 360
  Hib disease, 262, 320, 321
  See also Vaccine-preventable diseases
Impetigo, 329-331
Indicators of child abuse, 216-219
Infant Feeding Guide, 161
Infants and toddlers
  changing surfaces, 79
  feeding, 161-164
  furniture and equipment, 80-83
  nutritional problems, 179-181
  play areas, 86
  safety, 78-86
  special needs resources, 207
  toys and play materials, 79-85
Infectious diseases, 147-148, 257-382
  control and prevention, 260-262, 271-272; *See* individual diseases
  exclusion from center, 270; *See* individual diseases
  immunization, 262-265
  reporting, 265-269; *See* individual diseases
  types
    blood contact infections, 358-367
    direct contact, 327-357
      generalized infections, 348-357
      skin and superficial infections, 327-344
    intestinal, 272-300
    non-contagious, 377-382
    respiratory, 302-326
    vaccine-preventable, 368-376
  See also individual diseases; Sanitation
Influenza, 304-306
Injury report, 100-101, 109, 225
  sample form, 114
Insect bites, 77
Insect (pest) control, 43-44, 194-195
Insulin reaction, 250-252
Integrated health education, 22
  sample objectives, 24-25
Integrated Preschool Programs, 208
Intestinal diseases, 272-300
  control and prevention, 272-274
  reporting, 273
  sample letters to parents; *See* letters to parents
  types
    Campylobacter, 291-294
    Giardia lamblia, 278-282
    Hepatitis A, 298-301
    infectious diarrhea, 275-277
    pinworms, 295-297
    Salmonella, 287-290
    Shigella, 283-286

Kitchen facilities, 45-48
  cleaning, 193-194
  poisoning, 72
  safety, 65-66
  See also Food preparation and handling

Lactose intolerance, 178-179
Laundry, 49
  infectious diseases, 339, 342-343
Lead poisoning, 176, 229-233
  prevention, 232-233
  screening and treatment, 137, 230-232
  sources, 230
Letters to parents
  Campylobacter, 293-294
  chickenpox, 314
  conjunctivitis, 337
  Giardia lamblia, 281-282
  head lice, 345-347
  Hepatitis A, 301
  Hib disease, 322
  impetigo, 331
  meningococcal illnesses, 318
  pinworms, 297
  ringworm, 334

  Salmonella, 289-290
  scabies, 340
  Shigella, 285-286
  strep throat, 310-311
Local Education Agency (LEA), 207-208
Lyme Disease (LD). *See* Tick-borne diseases

McCarthy Screening Test (MST), 131
Mandated reporter (child abuse), 213, 215
Mantoux test, 324
Massachusetts agencies and services programs
  Childhood Lead Poisoning Prevention Program, 230, 233
  Department of Mental Health (DMH), 209-210
  Department of Public Health (DPH), 263-264, 267-268
  Department of Social Services (DSS), 210, 213, 220-225
  Massachusetts Nutrition Resource Center (MNRC), 200
  Office for Children, 100-101, 210-211
  Passenger Safety Program and Resource Center, 89
  Poison Control Center, 109-110
  Statewide Comprehensive Injury Prevention
Program (SCIPP), 64, 87
  See also names of individual agencies
Measles, 370
Medical examinations, 138-140
  staff, 145-146
Medication, 397-399
Meningococcal illnesses, 315-318
Menu planning, 186-190
Metabolic problems, 181
Middle ear infection, 377-378
Minneapolis Preschool Screening Instrument (MPSI), 131
Monilial (Candida) infections, 379
Mumps, 371

Nits. *See* Head lice
Non-contagious infectious diseases, 377-382
  monilial (Candida), 379
  otitis media (ear infections), 377-378
  tick-borne, 380-382
Nursing bottle mouth, 158, 163
Nutrition, 159-201
  community resources, 195-200
  dental health, 151-152
  diet, 171-173
  eating environment and habits, 164, 170
  education, 183-186
  food groups, 165-166
  food preparation and handling, 186-194
  infants and toddlers, 161-164
  special problems, 173-180
Nutrition Education and Training Program (NETP), 197-198
Nutrition Hotline, 200
Nutrition Resource Center, 200

Obesity, 175, 180
Office for Chidren (OFC), 210-211
  regulations, 100-101, 225
Otitis media (ear infections), 377-378
Outreach and Training Teams, 209

Parents
  child abuse, 220-221
  communicating with, 132, 385
  emergencies, 100-101
  health education, 20-22, 98, 111, 154
  health histories, 126
  infectious diseases, 271
  nutrition, 185-186
  sample letters to, *See* Letters to parents
  sample emergency transportation permission form, 113
Passenger Safety Program and Resource Center, 89
Pedestrian safety, 75-76
Pediatrician, 9
Pediculosis (head lice), 341-347
Pertussis (whooping cough), 376
Pest control, 43-44, 193
Pets, 44
Pink eye (conjunctivitis), 335-337
Pinworms, 295-297
Plants, poisonous, 68-70
Playground safety, 72-74
Playpens, 83
Play risks, 37-39
  art supplies, 70-71
  gross motor equipment, 67-68, 73-74
  infants and toddlers, 84-85
  playgrounds, 72-73
  seasonal, 76-78
Plumbing, 31-32, 51
Poison Control Center, 109-110
Poisons
  arts and crafts materials, 70-71

  batteries, 72
  cooking and kitchen utensils, 72
  diapering, 72
  emergency, 109-110
  lead, 137, 176, 229-233
  plants, 68-70
Policy. *See* Health policy
Polio, 373
Pools, 39-40
Potty chairs, 50, 58
Pregnancy and CMV, 350
Preschool Enrichment Team (P.E.T.), 130, 209
Preschool Feeding Guide, 164
Preschool health curriculum. *See* Health curriculum, preschool
Preventive child health care, 121-138
  health histories, 126
  health observation, 126-132
  medical examinations, 138
  primary services, 122
  Project Good Health, 122-124
  screening, 125, 131, 133-137
  See also Adult health; Dental health; Nutrition; Safety
Project Good Health, 122-124
Pure tone hearing screening, 136

Rashes, 392-395. *See* Direct Contact Diseases
Records. *See* Health Records
Regional Education Centers, 208
Reporting child abuse, 215-225
Reporting diseases, 265-269, 273, 357, 361-362
Respiratory diseases, 302-326
  control and prevention, 302-304
  sample letters to parents, *See* Letters to parents
  types
    chickenpox and shingles, 312-314
    Hib disease, 319-322
    meningococcal, 315-318
    streptococcal, 307-309
    tuberculosis, 323-326
    viral, (colds, flu), 304-306
Reye's Syndrome, 313
Rheumatic fever, 245, 246, 307-309
Ringworm (Tinea), 332-334
Rocky Mountain Spotted Fever. *See* Tick-borne diseases
Roseola, 304-306
Rubella (German measles), 372
SAFE DAYCARE, 64, 87
Safety, 37-39, 63-87
  art supplies, 70-71
  choking, 66-67, 170
  education, 86-87
  electrical wiring, 66
  field trips, 76
  infants and toddlers, 78-86
  kitchen facilities, 65-66
  outdoors, 72-78
  pedestrian, 75
  play areas, 65
  playgrounds, 72-74
  poisonous plants, 68-70
  seasonal, 76-78, 395-396
  toys and play materials, 67-68
  transportation, 89-98
  tricycles, 73-75
  water, 77
  See also Environmental concerns
Salmonella, 287-290
Sand, 40
Sanitation, 41-51
  garbage disposal, 49
  handwashing, 30-33, 44-45
  housekeeping, 42-44
  kitchen facilities, 45-48
  laundry, 49
  personal items, 328
  toilet facilities and plumbing, 31-32, 50-51
  See also Environmental concerns; Toileting
Seizures, 246-248
Scabies, 338-340
Scarlet fever, 307-309
Screening. *See* Health screening
Sexual abuse. *See* Child abuse and neglect
Sexually transmitted diseases, 355-357
  AIDS/HIV, 364-367
  Hepatitis B, 359-363
Shigella, 283-286
Shingles, 312-313
Sick child care, 383-404
  family day care, 403-404
  "get well" room, 402
  medication, 397-398
  policy, 384-387
  separate facility, 403
  types of minor illness and symptoms
    colds, 390
    constipation, 395

    fevers, 387-390
    heat exhaustion, 396
    rashes, 392-395
    sunburn, 395-396
    vomiting and nausea, 391
Sickle cell anemia, 249-250
Skin and superficial infections, 327-344.
        See Direct Contact Diseases
Skin products, 393
Snellen E (Tumbling E) Test (vision screening),
        135
Space, 33-34, 51
  safety, 65-66
Special education, 207-209
Special needs, children with, 205-211
  community resources, 207-211
  programming considerations, 205-206
  See also Child abuse and neglect; Chronic
        health conditions; Lead poisoning
Special Supplemental Food Program for Women,
        Infants & Children (WIC), 197
Staff
  health, 143-150
  health education, 20-22, 210
  personnel policy, 148-150
  relations with parents, 132
  responsibilities, 4-7, 94, 95-96, 103
  screening (for hiring), 227-228
  turnover, 37
Standards for Care of Children with Clinical
        AIDS, 367
Statewide Comprehensive Injury Prevention
        Program (SCIPP), 64,87
Strep throat, 246, 307-311
Streptococcal infections (group A), 307-311
Strollers, 82
Sudden Infant Death Syndrome (SIDS), 226
Sunburn, 76-77, 395-396

Taking a temperature, 389
Teething, 395
Tetanus, 375
Throat culture, 308, 309
Tick-borne diseases, 380-382
Tinea (ringworm), 332-334
Toilet facilities and plumbing, 31-32, 50-51
Toileting, 50, 53-59
  hygiene, 58-59
  See also Sanitation
Toilet learning, 55-59
Toys and play materials
  risks, 38-39, 67-68
  infants and toddlers, 84-85
Training, staff/parent, 20-22
Transportation safety, 89-98
  car seats and restraints, 91-93
  emergencies, 92-95
  equipment and information, 94-95
  field trips and carpools, 95-96
  policy, 89-90
Tricycles, safety, 73-74
Tuberculosis (TB), 323-326
Turnover, staff/children, 37
Tympanometry (hearing screening), 136

Underweight children, 180-181
United Cerebral Palsy (UCP), 211
USDA
  Child Care Food Program (CCFP), 186-187,
        195-196
  Food Distribution Program, 196-197

Vaccination. *See* Immunization
Vaccine-preventable diseases, 368-376
  immunization, 368-369
  types
    diphtheria, 374
    measles, 370
    mumps, 371
    pertussis (whooping cough), 376
    polio, 373
    rubella (German Measles), 372
    tetanus, 375
  See also Immunization
Viral illnesses, 304-306
Vision screening, 134-135
Visiting Nurses Associations (VNAs), 207
Vomiting and nausea, 391

Walkers, 80
Water safety, 38-39, 77
Water table, 38
Whooping cough (Pertussis), 376

Yeast infections (Candida), 379